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ABSTRACT

This document provides basic information to help school districts, health personnel serving schools, and community partners work together to design and provide safe, effective school health systems. The 12 chapters include: (1) "School Nursing and Today's Community"; (2) "School Nursing: Profession and Practice"; (3) "Health Literacy"; (4) "Communicable Disease Control and Immunization; (5) "Medication Administration"; (6) "Child Protection"; (7) "Health Appraisals"; (8) "Illness and Injury Care"; (9) "Emergency Services"; (10) "Children with Special Health-Care Needs"; (11) "Administrative Issues"; and (12) "National, Regional, and State Resources." Each chapter includes an introduction, a discussion of legal considerations, information on the school nurse's role, and references. There are 53 appendixes with technical information for school nurses. (SM)

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SCHOOL NURSING AND HEALTH SERVICES

A Resource and Planning Guide

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School Nursing and Health Services: A Resource and Planning Guide

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Foreword

Wisconsin has a long and proud tradition of educating its children. Working with families and communities, public schools have provided quality educational opportunities for 150 years.

Indeed, schools and communities must work with parents to ensure students' success. So, too, should they work with parents to help provide safe and healthy childhoods. The evidence is clear–students who are healthy and are not struggling with myriad conditions that place them at risk are students who are more likely to succeed in school and beyond.

Never has the role of the school nurse been more important. Our belief that every child deserves the opportunity to learn brings chronically ill or disabled children to our schools who, only a century ago, might have been denied access. Children are sent to school today with illnesses–fevers, coughs, and upset stomachs–that might well have kept them at home in the era of the single wage-earner. Today, school nurses routinely tend to children with complex, long-term health-care needs as well as those who simply "don't feel well."

In addition to attending to the ill and the injured, school nurses take an active role in education programs and in school and community disease-prevention efforts. In so doing, they interact with school staff and community health-care providers to design healthy learning environments and implement effective strategies for enhancing students' physical, mental, and emotional well-being, which in turn is critical to their academic success.

The school nurse is a catalyst for collaboration among families, school personnel, and community health-care providers. The quality and success of school health-service programs depend on a shared vision; sufficient funding; school health management, information, and service systems; and competent, committed school personnel, including school nurses.

The development of this guide follows through on the commitment of the Department of Public Instruction to establish and enhance school health-service programs. That commitment is articulated in the mission statement of the School Nursing and Health Services Resource Guide Task Force:

> ...to assist school districts, health personnel serving schools, and community partners to design and provide safe, effective school health systems that promote health, development, and well-being and remove health-related barriers to learning for all children in Wisconsin schools.

Appreciation is extended to the task force members and the education and health-care communities that contributed so significantly to this effort.

John T. Benson
State Superintendent

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Special thanks go to the Horicon School District and the Horicon High School Student Council for hosting a walk for cystic fibrosis, which provided healthy school and community interaction for the cover photograph.

Finally, deep gratitude is expressed to the school children of Wisconsin, many of whom I have come to know through direct and indirect contact. In the pain and desolation of their ill health, they have provided experiences from which we all continue to learn. In the their boundless life and future promise, they have given meaning to our present.

Introduction

School Nursing in the United States began in the early 1900s to keep "contagion" (communicable diseases) out of the schools. Lillian Wald, in New York, is credited with being the first school nurse. Daily inspections in the New York schools were made for fever, rashes, and lice. In the 20th century, improvements in housing, sanitation, and public health practices—such as vaccines and antibiotics—lessened the need for the "contagion watch," and the provision of first aid, health screenings, and health education became more predominant (Oda, 1991).

In 1969, Myerstien reported school children to be the "healthiest group in the population." This truism is still widely accepted today. Why this is so is not clear. Lynch (1983) notes that while it is apparent that school children die with less frequency than infants and the elderly and are less physically disabled than the aged, it is also known that certain conditions, such as child abuse, neglect, and delinquency, are confined to children; that disruptions in childhood, such as pregnancy, adversely affect all subsequent development; that chronic health conditions in childhood, present longer term disability compared to a similarly afflicted mature person; that more children are susceptible to the physical, emotional, and social hazards of the environment; that much disease of the young and over half of the deaths in this population group are preventable; and that schools present the only environment in which certain disease states, such as learning problems, are seen. The 1990 report *Code Blue: Uniting for Healthier Youth* affirmed Lynch's observations, stating, "Never before has one generation of children been less healthy, less cared for or less prepared for life than their parents were at the same age."

Health screenings and first aid are no longer the primary focus of the professional school nurse. The contemporary school-nursing practice addresses a population presenting multiple, pressing, varied, and complex health problems and needs. While the day-to-day health problems may not be life threatening, they require the type of decision making and skills that come from a registered nurse with that specialty expertise.

School nurses are one of the few health professionals available in the school setting prepared to assess and address the health issues and needs that students bring through the school doors. Yet challenges exist that make effectively responding to these health needs of school-age children difficult. School nurses are called to action to address these issues from individual, group, and systems perspectives. As a profession, we must

- decrease the natural isolation of school health professionals from one another by partnering with school administrators and public health officials to establish organizational structures that provide clinical supervision and consultation for nurses, enhancing the provision of safe and appropriate school health services, fostering professional growth, and inviting collaborative research related to student health and education outcomes in the school setting.
- increase the participation of school health professionals in policy making. This can be accomplished at the local level by partnering with members of boards of education and health and school administrators to understand the legal requirements within the education and health fields, professional school nursing practice, and by developing school health information, management, and service systems that provide the information necessary to monitor trends and inform policy development.
- increase awareness of the school nurse's unique role in interpreting the complex health needs of students by facilitating ongoing dialogue with school administrators and staff,

community organizations, and local health and human services providers that fosters a mutual commitment to and responsibility for student health and educational achievement.
- ensure nurses have the educational preparation and demonstrated competency in the specialty practice of school nursing, design innovative funding mechanisms for school health services, and establish inter- and intradisciplinary working relationships within and outside school systems to increase awareness of the interactive nature of the education and health missions.

This guide was developed by school and public health nurses, educators, health-care providers, administrators, student services providers, parents, and university professors who intend the document to be a stepping stone to bring about those actions. The guide is not intended to be a substitute for more comprehensive texts on information and management systems, federal and state law, specific health conditions, and the like. However, it provides fundamental information necessary to assist school districts, health personnel serving schools, and community partners working together to design and provide safe, effective school health systems. These school systems will support the health and academic achievement of Wisconsin's school-age children by modifying and/or removing health-related barriers to learning and promoting the health and well-being of all children in Wisconsin schools.

Resources

Lynch, A. *Redesigning School Health Services*. New York: *Human Sciences Press*, 1983.

Myerstein, A. "The Value of Periodic School Health Examinations." *American Journal of Public Health* 59 (1969): 1910-1926.

National Commission on the Role of the School and the Community in Improving Adolescent Health. *Code Blue: Uniting for Healthier Youth*. Alexandria, VA: National Association of State Boards of Education, 1990.

Oda, D. "Is School Nursing Really an Invisible Practice?" *Nursing Outlook* 39 (1991): 16-29.

School Nursing and Today's Community

1

Introduction

This guide to school nursing and health services is founded on the principles that (1) a connection exists between children's health needs and learning and (2) that we have to see today's children in their own world:

- at school
- on the athletic field
- at home
- in their neighborhoods
- at church, temple, or mosque
- even at the mall

Children today deal with a vast array of complex health and education issues, from the spectre of AIDS to the personal computer, that even two decades ago would have seemed unimaginable. Yet, today's children are similar to their parents in a number of ways. Namely, they need to be loved, cared for, listened to, cheered on, and assured that they are important. Every child who experiences such support has the opportunity to become a healthy, resilient, successful learner. This can only happen when every adult in a child's life is willing to nurture that child's growth, learning, health, and well-being.

Schools, Nursing, and "The Wisconsin Framework"

The fundamental purpose of school nursing is to help students participate fully in their learning by preventing, removing, and/or reducing health-related barriers that interfere with their development and learning.

"The Wisconsin Framework for Comprehensive School Health Programs" (Figure 1) enunciates a multi-strategy approach for promoting the health, well-being, and development of students and other members of the community as an integral part of a school's mission. The core of this strategy is a vision of the student as a successful, healthy learner.

"The Wisconsin Framework" is a collection of empirically supported strategies, organized into six components that are most effective and efficient when implemented in a coordinated manner:

- Healthy School Environment
- Curriculum, Instruction, and Assessment
- Student Services
- Student Programs
- Adult Programs
- Family and Community Connections

Such a comprehensive school health program is neither discipline-specific nor discipline-driven. Instead, it supports and promotes the healthy development of children through a variety of disciplines, programs, services, and individuals. In so doing, it helps build a system that ensures children have the greatest potential to overcome challenges and become healthy and productive citizens.

Working as partners with other members of the school and community, the school nurse can play a vital role in the development and implementation of the framework's six components. In fact, schools provide communities with an ideal setting from which to offer residents of all ages extra-academic services, including health screenings and counseling, immunizations, and programs that address health-related issues like parenting and substance abuse prevention. Naturally, such school-based instructional programs have an educational purpose, and teachers will use familiar educational methods to present the information. However, as the "Framework" indicates, curriculum, instruction, and assessment in schools are important pieces of a complex system.

Health instruction for students should converge with adult programs, student programs, and student services, drawing from the experiences of families and the community at large. For instance, a classroom teacher can certainly present an effective unit on communicable disease control. Yet, the inclusion of health professionals and others from outside the school environment can offer a richer, more meaningful lesson.

When a teacher invites a public health nurse to describe signs and symptoms of polio, a physician to define the long-term effects of the illness, or a polio survivor to relate personal experiences, students will likely learn far more than a silent, lifeless textbook can offer. Afterwards, students will also likely find greater meaning when reading a biography of Jonas Salk or contemplating the Andrew Wyeth painting "Christina's World." Such an approach both integrates "real life" into the academic experience and, in so doing, helps students better prepare for the complex challenges and responsibilities that life offers.

Similarly, such integrated programs help community members—some of whose primary connection to the district and its children is an annual vote in a school board election—better understand and appreciate their "ownership" of and responsibility for local schools, whether or not they have children who currently attend.

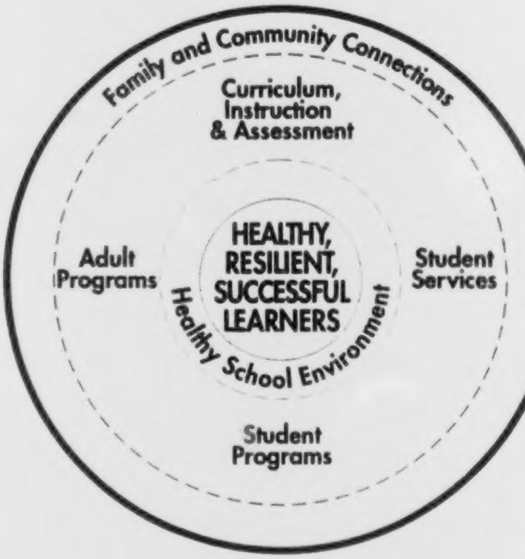
It is important to note here that many people support community-based programs and services. This important work should continue.

The purpose of this resource guide, however, is to empower readers to give broader consideration to the ways such community programs might be more effectively connected with school-based health programs which are often offered by school nursing services. This is a process that requires a reciprocal, interdependent, and interwoven relationship (Margaret Schmelzer, 1994).

The "Wisconsin Framework" reinforces that connections are essential, particularly noting the clear connections between the community and the school's educational programs. On the one hand, in terms of children and their families, the connections are personal. Parents and families pro-

Figure 1

The Wisconsin Framework for Comprehensive School Health Programs


Family and Community Connections
Curriculum, Instruction & Assessment
Adult Programs
Student Services
HEALTHY, RESILIENT, SUCCESSFUL LEARNERS
Healthy School Environment
Student Programs

vide the initial connection of love and belonging, which allows the child the confidence to form more connections beyond the family. On the other hand, in terms of schools and communities, the connections are societal. These connections allow children to recognize and accept themselves as critical thinkers, lifelong learners, active citizens, and ethical individuals.

Student Growth and Development

It is crucial that parents, educators, health-care providers, and community members take steps to link schools and communities in enduring ways that help children achieve positive developmental, health, and educational growth. In order to do that, there must be a common understanding of developmental growth as it affects health and learning. In *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, Morris Green offers tips (Figure 2) on how to encourage the healthy development of children during crucial phases of their development from kindergarten through high school, as they experience two primary phases of development: school-age and adolescence. The types and levels of development influence each group's health needs.

School-Age Years (Ages 6-11)

The health of children is strongly related to the quality of the environment in which they live, learn, and play. Factors such as poverty, access to quality day care and health care, parents who

Figure 2

Bright Futures

Goals for the Family

- Be positive ethical and behavioral role models
- Give praise and respect
- Foster communication
- Handle anger constructively
- Maintain regular interest in activities and school
- Facilitate independence
- Limit challenging behaviors
- Know child's friends and their families
- Set reasonable expectations

Goals for Community Interaction

- Participate in social, religious, cultural, or recreational organizations
- Be familiar with resources for health care and living expenses
- Engage in social responsibility to make community safe
- Attend current and cultural events
- Support health-promotion and disease-prevention education activities
- Attend college, vocational training, or work options
- Do community service

Figure 3

Goals for School-Age Youth

Developmental

- Acquire verbal and written language skills
- Increase vocabulary and complexity of thought
- Synthesize language, perception, and abstraction
- Involve self with school community

Social-Emotional

- Take pride in achievement
- Acquire a sense of self-worth and self-esteem
- Acquire a sense of personhood
- Achieve acceptance in peer group
- Develop morally and spiritually
- Acquire freedom of personal expression

Physical

- Increase strength and motor coordination
- Participate in individual or team recreation and sports
- For children with special health needs or chronic illness, develop a clearer sense of self and increase ability to care for self
- Prepare for puberty
- Grow permanent teeth

work outside the home, violence, and encouragement for attaining an education all play a role in the development of the school-age child. *Bright Futures* also includes goals for this age group (Figure 3).

In general, good health and resiliency are characteristics of the school-age child that make serious illness or death relatively infrequent events. During the school-age years, a child's growth rate is somewhat slower than in previous years and much less rapid than during adolescence. Increases in strength and motor coordination occur. This is a critical time for children with physical disabilities or chronic illnesses to successfully adapt to their health condition.

In addition, school-age children learn to read, write, and communicate with increasing complexity and creativity. They also usually become more independent and begin to sense their role in their peer group, family, and community. Parental encouragement of learning is essential to the child's self-esteem and success in school.

As children grow and gain increasing independence to explore their environment, accidental injuries contribute to almost half of all deaths among children ages six to 11. Of these deaths, nearly half result from motor vehicle injuries.

Adolescence (Ages 12-18)

Adolescence is a period of unprecedented physical, cognitive, and emotional development (Figure 4), marked by:

- significant physical/sexual maturation,
- establishment of an individual identity and intimate relationships,
- cognitive and moral development,
- an end to secondary school education, and
- entry into the workforce.

A number of significant societal changes affect adolescent development, making adolescence more unpredictable and parenting more complex as families struggle to cope. Such factors include:

- blended families,
- single-parent households,
- two-income families,
- poverty in young families,
- absence of health insurance coverage, and
- changes in adult attitudes and behavior.

As these challenges shift, modern medicine and health care continue to advance. Societal changes and advances in medicine have resulted in a shift in adolescent mortality and morbidity from primarily infectious causes to primarily preventable social and environmental causes. Presently, the leading causes of death for teens are motor vehicle injuries, other injuries, and suicides or homicides. Schools and communities need to support teenagers and parents as they adapt to these changes, so individuals, families, and schools can eliminate factors which may lead to destructive behaviors.

Student Population Profiles

A statistical snapshot of Wisconsin school children—highlighting size and age distribution, education, poverty, health insurance status, household status, chronic illness, immunizations, oral health, and youth risk behaviors—helps, in part, to define the challenges that teachers, school nurses, and others face in educating today's students.

Figure 4

Goals for the Adolescent

Developmental

- Acquire further verbal and written language skills
- Acquire more complex problem-solving abilities
- Make educational, vocational, and personal choices
- Involve self in school and community activities

Social-Emotional

- Mature socially and emotionally
- Handle emotional separation and individuation
- Maintain peer relationships
- Develop strong values
- Experience intimate relationships
- Recognize strengths
- Manage stress and conflict
- Fulfill religious and spiritual needs
- Set reasonable but challenging goals

Physical

- Increase height and weight to adult level
- Grow and develop sexually
- Increase strength and motor coordination
- Participate in individual or team recreation and sports

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Size and Age Distribution

In 1993, Wisconsin's population was estimated at 5,038,000. Of the state's total population, 1,341,000, or approximately 26.6 percent, were newborn to 17 years; approximately 20 percent were from five to 17 years of age (see Figure 5).

Despite the rapid growth of racial and ethnic groups in Wisconsin, the state's population was still primarily non-Hispanic white (91 percent) in 1990. During that year, Wisconsin's 247,000 African-Americans represented the largest minority group, accounting for approximately five percent of the total population (see Figure 6).

Between 1980 and 1990, Wisconsin's Asian population nearly doubled to almost 54,000 citizens, making it the state's fastest-growing racial minority group (Maternal and Child Health Report, 1993).

As these minority groups grow in size and percentage of the population, it is important that educators and health-care providers recognize, just as they do with the non-Hispanic white student population, that there is a range of unique health and educational needs within each minority population.

Education

Although the graduation rates for Asians, non-Hispanic whites, Native Americans, and Hispanics increased from the school years of 1994-95 to 1995-96, the rates decreased for African-Americans. In 1994-95, non-Hispanic whites had the highest graduation rate, but fell to second during 1995-96. During that same period, the only other graduation rate to fall was that of African-American students (see Figure 7).

The impact of high graduation rates on a community is a positive one. Although the entire community may celebrate when individuals excel academically and win awards or other public recognition, a high graduation rate for all students indicates a level of preparedness that underscores the health of the entire community.

Figure 5

Estimated Wisconsin Population Proportions by Age, 1993

Age	<1 year	1-4 years	5-17 years	18-44 years	45-64 years	> 65 years	Total
Number	70,000	284,000	987,000	2,068,000	953,000	676,000	5,038,000
Percent	1.4	5.6	19.6	41.0	18.9	13.4	100.0

Source: Wisconsin Division of Health, Center for Health Statistics

Figure 6

Wisconsin Population by Race and Ancestry, 1990 Census

Age	Total	White	African-American	Native American	Asian	Hispanic*
5-9	375,263	324,970	27,570	4,118	7,059	11,546
10-14	353,006	308,916	25,202	3,790	4,843	10,255
15-19	348,758	307,238	23,834	3,580	5,028	9,078
all others	3,814,742	3,525,146	165,563	26,297	35,418	62,318

*Hispanic may be of any race.

Source: Wisconsin Division of Health, Center for Health Statistics / Wisconsin Modified Age and Race File, Bureau of the Census, 1992.

Figure 7

Graduation Rates by Race or Ethnicity in Wisconsin

	1994-95 SY		1995-96 SY	
Race or Ethnic Group	**Grads**	**Grad Rate (%)**	**Grads**	**Grad Rate (%)**
Asian	967	88.72	999	92.33
African-American	2,030	79.36	1,993	78.81
Hispanic	942	81.35	1,004	84.80
Native-American	442	76.60	490	76.80
White	47,354	91.02	48,132	91.93
Totals	51,735	91.06*	52,618	90.23*

* Provisional data based on reports which do not include some school districts.

Source: Wisconsin Department of Public Instruction

Poverty and Health Insurance Status

According to 1990 Wisconsin census data, 11 percent of state residents lived in poverty. In fact, 41 percent of African-Americans, 35 percent of Native Americans, 41 percent of Asians, and 27 percent of Hispanics in Wisconsin lived below the poverty level. And the poverty rate for state children of all races was 14.9 percent.

According to the 1995 *Wiskids Count* bulletin, children from ethnic minority groups are two-to-four times more likely to live in poverty. Almost 56 percent of Wisconsin's African-American children live in poverty, which ranks Wisconsin last among the states and the District of Columbia for the percentage of African-American children living in poverty.

Poverty is most frequent among Wisconsin's youngest children. According to the 1990 census, 18 percent of Wisconsin children ages five and under live in impoverished families. The poverty rate was 15 percent among children from 6 to 11 years of age, and 12 percent for those ages 12 to 17 years.

Low-income families often have limited access to health insurance, and their children tend to be less healthy than children from more affluent families (see Figure 8). The resulting difficulty in obtaining regular medical care—including regular physical examinations, vision testing, immunizations, and dental care—may increase the potential for poor health, which in turn threatens the child's ability to learn (Williams and Miller, 1991).

Figure 8

Health Insurance Access

Group	Ages	Number or Percent	Source
Enrollment of children in Medical Assistance	0-5 6-19	115,047 160,127	*Medicaid Eligibility Summary Report, February 1998*
Uninsured children (neither private insurance or Medical Assistance)	0-18 0-5 6-17	7.6% 7.2% 7.8%	*Wisconsin Family Health Survey, 1996*
Estimated number of children uninsured in households below 200 percent of poverty level	0-18	66,000	*Wisconsin Family Health Survey, 1996*

Where poverty may have had an impact on a student during the critical early development years before age 5, school nurses, their student-services colleagues, and educators will need to assess the consequences of such circumstances in order to support the child's health and educational progress.

Household Status

One in four American (and Wisconsin) children live in single-parent households. While 75 percent of Wisconsin children live with both parents, only 25 percent of African-American children live with both parents. Of the single-parent African-American households, 55 percent are headed by mothers and only 3 percent by fathers. Understandably, single-parent families have less flexibility when responding to their children's learning and health needs.

In addition, according to the *Wiskids Count Data Book 1995*, the number of children in foster care increased from 6,699 in 1990 to 7,786 in 1993. And the average daily population of residents in Wisconsin's secure juvenile correction institutions increased from 1993-94 by 12 percent to 791 incarcerated juveniles.

Chronic Illness

The 1990 census shows that of the 1,518,725 children and youth under age 21 in Wisconsin, as many as 15 percent (227,808) have a chronic or disabling health condition. Most of these are mild, such as asthma (regularly handled by school staff members), and interfere only slightly in a child's activities. Attention deficit disorder is another chronic condition requiring regular attention by educators and health-care providers.

On the more serious side, about 5 percent (75,936) of Wisconsin children have a condition that requires specialized health-care and related services. An additional 2 percent (30,375) live with severe conditions that create special challenges for the child, the family, and the school (see Figure 9).

Figure 9

Chronic Illness

Primary Disability	Prevalence Rate[1] (%)	Unduplicated Count	Source[3]
Asthma	8.7	124,000[2]	*Wisconsin Family Health Survey, 1996*
Autism	0.1	1,055	
Cognitive Disability	1.31	13,455	
Deaf/Blind	0.001	9	
Developmental Delays	4.0	53,700[2]	*Zill and Schoenborn, 1988*
Emotional Disturbance	1.59	16,337	
Hearing Handicap	0.15	1,547	
Learning Disability	4.55	46,781	
Other Health Impairment	0.31	3,193	
Orthopedic Impairment	0.18	1,889	
Speech and Language	2.69	27,653	
Traumatic Brain Injury	0.03	282	
Vision Handicap	0.04	436	

Note: All categories are for ages 3-21 except Developmental Delays, which is for ages 0-17

[1] The prevalence rate is equal to the particular count divided by the state's total school enrollment (public and private)

[2] Only population estimates are available

[3] All categories without an identified source come from statistics compiled on DPI form PI-2197 (December 1997)

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School staff members must be aware of students' special health-related educational needs in order to be prepared to address them. These special needs heighten the potential for educational difficulties and can engender feelings of helplessness among those involved in the student's life. Lack of knowledge about special health-related educational needs, as well as little or no preparation to deal with those needs, can make the school environment less safe for such students and their classmates.

Immunizations

For the 1996-97 school year, 96.3 percent of children in grades K-12 completed the required doses of vaccines, a rate that has remained fairly constant. In Wisconsin over the past few years, immunization rates for children entering kindergarten who had also completed their immunizations by the age of two have been as follows:

- 1991-92: 53.1 percent
- 1992-93: 56.1 percent
- 1993-94: 60.2 percent
- 1994-95: 57.2 percent
- 1995-96: 60.2 percent

When large numbers of children miss required immunizations, the risk of absenteeism among the entire school population due to preventable disease increases. Understandably, such circumstances can temporarily suspend or impair a student's academic progress. In addition, a serious outbreak of a vaccine-preventable disease or communicable disease can spread to the community if school and public health officials do not act promptly.

Oral Health

According to a 1989 U.S. Department of Health and Human Services report, nearly 25 percent of children are at high risk for dental disease. Although a 1996 Wisconsin Department of Health and Social Services survey indicates that 83 percent of children ages 3 to 17 had seen a dentist during the previous year (the same percentage as in 1994), lack of access to dental care for uninsured students and medical assistance recipients remains a significant problem. Only 30 percent of fee-for-service Medicaid recipients (ages 0-20) and only 20 percent of HMO recipients (ages 0-20) received a dental exam in 1996.

Poor oral health affects educational development in many ways. For instance, children whose mouths hurt because of lack of dental care are not likely to eat well. Consequently, they may be less alert and less likely to volunteer answers or participate in general. Adults may erroneously perceive such students as withdrawn or difficult.

Youth Risk Behavior

Risky behavior has been shown to slow educational progress and endanger student lives. Although the type of injuries seen in hospital discharge data (Figure 10) do not usually cause death, the three leading types of injuries that cause death are the same for ages 5-14 as they are for ages 15-19.

Figure 10

Ranking of Injuries by Age and Type, 1994

Injuries (1994)

Rank	Ages 5-14	Ages 15-19
1	Falls	Striking (accidental and assault)
2	Striking (accidental and assault)	Motor vehicle
3	Motor vehicle	Poisoning

Injury Deaths (1990-95)

Rank	Ages 5-14	Ages 15-19
1	Motor vehicle	Motor vehicle
2	Firearms	Firearms
3	Drowning	Drowning

Source: External Causes of Injuries and Death. *Wisconsin Center for Health Statistics death certificate data and Office of Health Care Information, 1994. Six-year data tabulated by the Office of Statistics and Programming, Centers for Disease Control and Prevention, Atlanta.*

The Youth Risk Behavior Survey (YRBS), conducted by the U.S. Centers for Disease Control and Prevention (CDC) in cooperation with the Wisconsin Department of Public Instruction, queried students in grades 9 through 12 on a variety of risk-oriented behaviors, including those related to injuries, drug and alcohol use, sexual activity, dietary patterns, and physical activity.

So that they can better identify and respond to risk behavior in the schools, nurses should carefully consider the results of the YRBS and related information.

Automobile and Bicycle Injuries

Twenty-five percent of the students responding to the CDC survey said they "always" wore their seat belts when riding in a car driven by someone else. Another 25 percent said they wore their seat belts "most of the time," and 27 percent said they "never" or "rarely" wore a seat belt.

Eighty percent reported riding a bicycle in the past 12 months. Almost all said they "never" or "rarely" wore a bicycle helmet when riding. Less than 5 percent reported wearing a helmet "always" or "most of the time." Though there was no change in reported seatbelt use between 1993 and 1997, there were small increases in reports of helmet use over that same time.

Students were also asked how many times during the previous 30 days they had either ridden in a car with a driver who had been drinking alcohol or had driven a car or other vehicle after they had been drinking alcohol. Over one-third reported riding with a driver who had been drinking at least once in the previous 30 days; 16 percent said they drove after drinking.

Weapons

Due to growing concerns over juvenile violence and criminal activity, the YRBS asked questions to determine students' risk of violence or accidental injury involving weapons.

During the study, 15 percent of students reported carrying a weapon—such as a gun, knife, or club—during the previous 30 days. Six percent of students polled said that they had carried a gun during that same period. A much lower percentage reported carrying a weapon on school property in the same time period.

The YRBS also sought information on victims. Of those surveyed, eight percent reported being threatened or injured with a weapon on school property within the previous 12 months. Three percent said that they had stayed home at least one day in the previous 12 months because they felt unsafe in school or traveling to school.

Violence

Physical fights appear to be a fairly common phenomenon among high school age students, though most appear to involve only minor or no injury. About 33 percent of students said that they had been involved in a physical fight at least once in the previous 12 months; 4 percent said they had to be treated by a doctor or nurse after a fight.

Nearly one in seven reported being hit, slapped, or threatened by a date; 8 percent of students reported being verbally or physically forced to have sex with someone else.

Suicide

According to the YRBS, 25 percent of all high school students reported seriously considering suicide during the previous 12 months. In addition, 20 percent reported attempting suicide in the same period; one out of every five of those students said the attempt resulted in injury that required medical attention.

The percent of students who reported seriously considering suicide remained relatively constant between 1993 and 1997. In 1993, 27 percent of students said they had seriously considered suicide; 25 percent of students in the 1997 study said they had done the same.

The percent of students who reported attempting suicide in the previous year increased significantly between 1993 and 1997, from nine percent to 20 percent, respectively. However, those who said their attempts required medical attention decreased from 30 percent to 20 percent during that same period.

Tobacco

Smoking is a major risk factor for heart disease; chronic bronchitis; emphysema; and cancers of the lung, larynx, pharynx, mouth, esophagus, pancreas, and bladder. Many efforts have been made to target teens and young adults to inform them about the dangers of smoking and to keep them from starting. Similarly new laws have been passed to make it harder for teens to get tobacco products. Despite these efforts, considerable numbers of teens still smoke or use tobacco. Sadly, tobacco use accounts for one in every six deaths in the United States; it's the most preventable cause of death in the U.S.

Just under half of all students reported never smoking a whole cigarette in their life. Of those who smoked a cigarette, over half had their first cigarette between the ages of 11 and 14. There was no significant statistical difference between 1993 and 1997 in each of these areas. There was, however, an increase in the number of students who had ever smoked who said that they had tried to quit smoking (from 19% to 35%).

Alcohol and Other Drugs

Only 23 percent of students said that they had never had a drink of alcohol. Over 25 percent of those students reported having had their first drink of alcohol before the age of 13. Fifty percent reported having had at least one alcoholic beverage in the previous 30 days, and nearly 33 percent reported having had five or more drinks at one time in the same period.

In addition,

- nearly 33 percent said they had tried marijuana.
- seven percent said that they had tried at least one form of cocaine.
- three percent had used cocaine in the previous 30 days.
- 16 percent said that they had used an inhalant to get high at least once in their life.
- four percent reported taking steroids without a doctor's prescription.

While there were no significant differences between students in the 1993 and 1997 samples with regard to measures of alcohol, cocaine, inhalants, and unprescribed steroid use, students in 1997 were more likely to have used marijuana than students in 1993.

Sexual Behaviors

Forty percent of students responding to the YRBS reported that they had had sexual intercourse; nearly half of those students said that they became sexually active when they were 15 or 16 years old, and one-quarter of them said that they drank alcohol or used drugs before their most recent sexual encounter. Sixty percent of sexually active students reported they had used a condom the last time they had sex. Seventy percent said they used condoms or birth control pills to prevent pregnancy the last time they had sex.

Those who reported having ever had sexual intercourse decreased from 47 percent in 1993 to 41 percent in 1997. There was no significant difference in the age at which students who have been sexually active reported having their first sexual intercourse. There are also no significant differences in the use of condoms or other forms of birth control. Roughly the same percentage of students reported using alcohol or drugs before their most recent sexual experience in 1993 and 1997.

According to the Center for Health Statistics (1996), 182 Wisconsin teens under 15 and 2,549 state teens 15 to 17 years old gave birth in 1995. Understandably, early pregnancy can significantly affect the education and future life decisions of these young mothers and their children.

Dietary Patterns

While it may, at first, seem a more benign form of risk taking, eating habits among students is also cause for concern, particularly in light of the growing presence of eating disorders among young men and women.

Dietary guidelines established by the U.S. Department of Agriculture in 1992 recommend that people eat five or more servings of fruits and vegetables, three or more servings of dairy products, and six or more servings of breads or grains each day. The USDA also recommends that people limit, as much as possible, their intake of food servings high in fat and sugar.

Unfortunately, Americans currently consume diets high in fat and low in complex carbohydrates and dietary fiber. Poor eating habits and inactivity are root causes of overweight and obese children and adolescents and can be a source of social and psychological stress (CDC, 1997); it is also likely to persist into adulthood, leading to such high-risk conditions as diabetes, heart disease, high blood pressure, stroke, some cancers, and gall bladder disease. Relatedly, the obsession of many with their physical build can lead to such devestating eating disorders as anorexia and bulimia. (For more information on anorexia and bulimia and the school nurse's role in addressing them, see Chapter 8.)

According to the Youth Risk Behavior Survey (YRBS), 15 percent of students surveyed said that they had not eaten fruits, vegetables, or juices from fruits or vegetables in the day before the study; nearly 50 percent said that they had consumed up to two servings of those foods or juices; just over 25 percent said they had three or four servings; and eight percent said they had five or more servings.

In the same survey, just under 33 percent of the respondents said they had not consumed any high-fat meats or fried foods on the day before the study, and 50 percent reported consuming up to two servings of such foods on the previous day.

In addition, nearly 50 percent of the respondents said they had consumed up to two servings of milk, cheese, or yogurt during the previous day; and nearly 50 percent said they had consumed three or four servings of the same foods during that time. Nearly the same number responded in the same way when asked about their intake of bread, pasta, rice, or crackers.

In that same survey, just over 50 percent of all young people said that they were "about the right weight." Just under 33 percent said they were "slightly" or "very" overweight, while about 17 percent said that they were "slightly" or "very" underweight.

As to how they were handling their current weight, over 40 percent of the young people said they were trying to lose weight, about 20 percent said they were trying to maintain the same weight, and 20 percent said they were doing nothing about their current weight.

While there are no significant differences in most of the YRBS statistics from 1993 to 1997, there was a significant increase in the number of students who said they had exercised to lose weight or maintain their current weight as well as decrease in the number of students who had consumed fruits or vegetables. Fortunately, in 1997 students reported eating high-fat meats and fried foods less regularly than did the students polled in 1993.

Physical Activity

Young people can build healthy bodies and establish healthy lifestyles by including physical activity in their daily lives. However, many young people are not physically active on a regular basis, and physical activity declines dramatically during adolescence. School and community programs can help young people get active and stay physically fit. Regular physical activity in childhood and adolescence helps control weight, improve strength and endurance, build healthy bones and muscle, reduce anxiety and stress, improve blood pressure and cholesterol levels, and, in so doing, increase self-esteem. Unfortunately, a recent report by the U.S. Surgeon General asserts that only about half of young people in the U.S. engage in regular physical activity, and 25 percent reported engaging in no vigorous activity at all (HHS, 1997).

Nearly 66 percent of the respondents in the YRBS said they had exercised or participated in physical activities for at least 20 minutes on at least three occasions during the previous week; 17 percent said they engaged in no such exercise in the previous week. In addition, nearly 50 percent of the respondents said they took part in physical education classes five days a week, while 33 percent said they had no physical education classes.

Challenges and Mission

This chapter, along with the health room and classroom experiences of school nurses and teachers statewide, makes it clear that Wisconsin students bring into their classrooms many health-related challenges to learning. Educators must be able to identify and address such challenges in order to effectively educate students.

Schools provide a central site through which districts and community agencies can offer programs to address the health and societal problems that exist in the broader community. School districts and community agencies which attempt to resolve complex problems and issues with a clear understanding of each partner's goals and purposes decrease the likelihood of fragmented, competitive, and reactive approaches to problem solving and community planning.

Schools and communities can succeed where individuals struggle, notes Kenneth Baldwin, Director of Wisconsin's Bureau of Public Health. "Individuals cannot personally address all the factors that affect their health and their family's health, but for those factors that they can control, they must begin to take responsibility for them and for their children. Finally while the burden of poor health is sometimes realized disproportionately by some of us, the solutions must be identified and carried out by all of us. To make real and long-lasting change requires the commitment of society as a whole to respond. We must have faith that this will be done."

Conclusion

Schools must strive to recognize partners, make connections, and understand the expectations that exist among themselves and others. In order to do this, they must first gather as much information as they can about the role and purpose of the work that they do. In choosing to know their partners by gathering such information, schools can put into motion the CSHP framework that helps to forge partnerships between schools and communities and serves as a catalyst to communication and, in the end, a shared vision.

School districts which make an effort to understand such partners, as well as their relationship to and need of such partners, should find that they have an integral ally in serving their students' educational and health needs. One of the district's greatest allies/team members in such efforts is, as this publication should make increasingly clear, the school nurse.

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School Nursing: Profession and Practice

2

Introduction

School nursing in the United States has existed for decades for the purpose of supporting the educational mission of schools by preventing, removing, and/or reducing barriers to student learning. In recent years, school nurses have become increasingly more integral to America's schools. The deepening of that relationship has been motivated and supported, in great part, by such legal initiatives as Section 504 of the Rehabilitation Act of 1973, the Individuals with Disabilities Education Act (IDEA and IDEA-Reauthorized 1997), and its predecessor, Public Law 94-142, all of which helped to make the distinct missions of schools and school nursing become more like mirror images of each other.

While better laws are now on the books and numerous excellent nursing-preparation programs exist in the United States, a limited number of nurse-training programs include a specialty in or focus on school nursing. Thus, nurses who undertake school nursing after graduation or upon leaving traditional hospital/clinic work are often unprepared for and overwhelmed by the unique demands of professional practice in the school environment. A nurse's related frustration can be heightened by the unique distinctions between the mission of schools and the mission of providing health care.

- Nursing preparation programs teach nurses to understand and support their profession within a variety of traditional health-care settings, where the mission of intervening to preserve and promote good health is consistent with the mission of nursing.
- A school's mission, however, focuses on and promotes academic learning, both creative and disciplined. Health issues tend to be seen as secondary—competing for space in the school day, the school building, and the school budget.

School nurses who struggle with their role in the school environment may be heartened by considering the strong parallels between nursing and teaching and the opportunities to develop partnerships with their education colleagues in ways that support the healthy development of children and youth. Pittman and Cahill (1992) suggest that what is urgently needed is a common view that education and other services are interactive and essential to the formulation of new, effective strategies for educational success. To develop a common view, they suggest that schools and communities

- develop a clear definition of what they want every young adolescent to be (that is, the outcomes adult society wants, the outcomes youth want, and the processes which will achieve those outcomes).
- develop a better understanding of how children and youth develop competencies and how those competencies interact.
- develop a better understanding of the various individuals within and outside the school, of institutions that can and should play an important role in youth development, and how these roles inter-relate; this last activity is explored relative to developing a better understanding of various individuals within the school setting.

Both teaching and nursing are "helping" professions that enhance the lives of those served: teaching is about helping others to be learners, and nursing is about supporting the healthy development of children, youth, families, and communities.

Chapter 1 provided data to understand factors and forces that influence the health of children and youth. This chapter will explore the role and practice issues of school nurses and those of others within the school building, the district, and the broader community and how these roles interact. Perhaps it will also stimulate enduring partnerships that support youth development and the achievement of educational goals.

Important Parallels

As with any profession, school nurses must rise to the challenge of balancing professional responsibilities with the quest to fulfill personal goals. Knowing how the professional responsibilities of different positions will interact with one's own job can make that balancing act even more fruitful. When nurses and teachers understand each other's work, they have the opportunity to eliminate confusion and more fully understand how their work interacts to support the development of competence and academic success in children.

Just as nurses have different styles and approaches to help promote the healthy development of children and youth, teachers have different styles and strategies for helping children learn. Those styles are usually defined or influenced by a unique mix of factors from the realm of profession and practice.

Both the nursing and teaching professions are influenced and shaped by outside forces and concepts, including licensing, credentialing, and degree programs, and by standards of professional practice and conduct. Such measuring devices help define the professions as a whole and involve or affect large groups of people.

Conversely, practice embodies the inner forces that drive the individual: background, training, personal style, and individual strengths and weaknesses. These factors help shape the individual's performance and behavior within the professional role.

School nurses who recognize that teachers also must balance external professional demands—such as certification, licensing, administrative tasks, and attention to legal and statutory responsibility and risks—with elements of personal practice may come to better understand their own jobs. Since school nursing is one of the fastest growing nursing specialties, this appreciation of the demands faced by teacher colleagues will increase the likelihood of a nurse's success in meeting the growing responsibilities for managing health-service programs and nursing services, whether the focus is on prevention, intervention, or primary health care.

Legal Considerations

The State of Wisconsin provides legal guidance regarding the type of health staff schools must have to meet the health and safety needs of students and staff. Wis. Stat. 121.02(g) requires school districts to provide emergency nursing services. The implementing administrative rule, PI 8.01 (g), states that a registered nurse licensed in Wisconsin must provide the direction for these emergency nursing services. In addition, federal laws such as the Individuals with Disabilities Education Act (IDEA), its implementing Wis. Stat. 115 and Wis. Admin. Code PI 11, and the U.S. Rehabilitation Act of 1973, Section 504 provide guidance regarding the type of school health staff needed to ensure the provision of services to children eligible under either of these programs.

A number of federal laws, state statutes, and local school board policies shape the nursing service programs that schools provide.

Individuals with Disabilities Education Act

The federal Individuals with Disabilities Education Act (IDEA) and its reauthorized version (IDEA-R97)—undergirded by Wis. stats. 115 and PI 11.02(45)—continue to regulate school nursing. Together, they require school districts to provide the related nursing services necessary to ensure that individual children benefit from special education programs.

U.S. Rehabilitation Act of 1973, Section 504

In addition, Section 504 of the U.S. Rehabilitation Act of 1973 requires school districts to provide every qualified handicapped person in the school's jurisdiction with general education, special education, related aids, and services designed to meet individual educational needs. (See Chapter 10 of this publication for more specific information about these federal laws and their application in Wisconsin schools.)

Wis. Stat. 121.02(g)– Emergency Nursing Services

Wis. Stat. 121.02(g) requires school districts to provide emergency nursing services. The implementing administrative rule (PI 8.01 (g)) states that a registered nurse who is licensed in Wisconsin must provide the direction for these emergency nursing services. Most Wisconsin school administrators and nurses know and refer to these rules collectively as "Standard (g)." It is important to note, however, that while some of the required school nursing services fall under Standard (g), many federal and state statutes relate to required school nursing services.

Wisconsin Nurse Practice Act

The Wisconsin Nurse Practice Act (Wis. Stat. 441 and Wis. Admin. Code N6 and N7) identify the scope of practice, standards of practice, and rules of conduct for registered nurses and licensed practical nurses working in any practice setting, including schools.

School Nursing Practice in Wisconsin Schools

The dynamic and expanding nature of school nursing practice demands an appropriate educational and skill level that enables the nurse to meet the contemporary health needs of students. Wisconsin universities and schools of nursing, like their counterparts in other states, are beginning to shape baccalaureate and masters programs that respond to the educational needs of nurses practicing in the school setting. All school nurses are encouraged to access educational opportunities to enhance their knowledge about the diverse and complex health issues of school-age children, their families, and school staff members. Further they are encouraged to build their skill level in the area of program management, thus, enabling them to become effective managers of school health-service programs.

School nurses in Wisconsin, including those practicing in expanded roles as pediatric, family nurse, or school nurse practitioners, are registered nurses who practice under a license issued by the Wisconsin Board of Nursing through the Department of Regulation and Licensing. Nurses here are governed by Wis. Stat. 441, the Nurse Practice Act, and related regulations. Just as in more traditional health-care settings, nurses in the school setting are responsible for adhering to standards of professional practice, including those related to conduct, confidentiality, delegation, and documentation.

Wis. Stat. 441.11(4) defines the practice of professional nursing as:

> ... performance for compensation of any act in the observation or care of the ill, injured or infirmed, or for the maintenance of health or prevention of illness of others, which act requires substantial nursing skill, knowledge or training, or application of nursing principles based on biological, physical and social sciences, such as observation and recording of symptoms and reactions, the execution of procedures and techniques in the treatment of the sick under the general or specific supervision or direction of a physician, podiatrist licensed under ch. 448 or dentist licensed under ch. 447, or under an order of a person who is licensed to practice medicine, podiatry or dentistry in another state if that person has prepared the order after examining the patient in another state and directs that the order be carried out in this state, and the execution of general nursing procedures and techniques. Except as provided in s. 50.04 (2)(b), the practice of professional nursing includes the supervision of a patient and the supervision and direction of licensed practical nurses and less skilled assistants.

Standards of practice and rules of conduct for registered nurses and licensed practical nurses are articulated in Wis. Admin. Codes N6 and N7.

School nurses are responsible for assessing the health needs of a given population—the students in a school district or school building—and developing a school health-service program to respond to those needs. To be effective, the school nurse must link the health-service program with the school curricula and student support services found within the school and among surrounding community agencies serving children and adolescents. The school nurse must also connect the school health-service program with the school's and child's social and physical environment.

Wis. Admin. Code N6.03(1)(a)(b)(c)(d) outlines the standards of practice for registered nurses. It states that RNs will use a critical-thinking process in carrying out general nursing procedures in the maintenance of health, prevention of illness, or care of the ill. This process also applies to the development and maintenance of a coordinated health-service program in the school setting. The critical-thinking process consists of the steps of assessment, planning, intervention, and evaluation, which are defined as follows:

- *Assessment:* The systematic and continual collection and analysis of data about the health status of a patient culminating in the formulation of a nursing diagnosis.
- *Planning:* The development of a nursing plan-of-care for a patient which includes goals and priorities derived from the nursing diagnosis.
- *Intervention:* The nursing action taken to implement the plan-of-care by directly administering care or by directing and supervising nursing acts delegated to LPNs or less-skilled assistants.
- *Evaluation:* The determination of the patient's progress or lack of progress toward goal achievement which may lead to modification of the nursing diagnosis and plan of care.

School Nurse Certification

School nurse certification is available through professional nursing organizations. The American Nurses' Credentialing Center (ANCC) offers a general examination in school nursing that ensures minimal preparation for practice in schools. The National Board for Certification of School Nurses also offers school nurse certification through examination. Eligibility for both examinations includes educational requirements and school nursing experience, and both organizations require continuing education to maintain certification.

Certification as a school nurse is offered through the Wisconsin Department of Public Instruction. Wis. Admin. Code PI 3 describes the requirements of certification for school nurses. While the current process is permissive, nurses and administrators should note that certification can be especially helpful because it clarifies the education, training, and experiential background nurses practicing or hoping to practice in the school setting will need to do their work most effectively. The certification requirements can also better prepare nurses whose background primarily includes experiences in traditional health-care settings for the unique work they will do in the school setting.

In the fall of 1994, the Department of Public Instruction collaborated with the Department of Health and Family Services, the School Nurses of Wisconsin, collegiate schools of nursing, and other partners in health and education organizations to review the school nurse certification requirements and propose revisions. Their proposed revisions respond to the knowledge and demonstrated competencies necessary to address the contemporary health needs of students in today's education system; as such, they set new standards for preparing newly licensed school nurses. No changes are proposed for currently licensed staff.

Proposed revisions were reviewed and supported by the State Superintendent's Administrative Rule Review Committee. Currently, the proposed School Nurse Licensure/Certification rules await public comment and review and approval by the state Legislature. The School Nurse Certification Requirements in effect at this time are found in Figure 11.

Staffing

In Wisconsin, local school boards decide who will provide school health services. The school district may employ registered nurses and other school health personnel to provide the health services in the district and/or may contract with another organization to coordinate and provide necessary health services.

Local school districts provide school health services through a variety of staffing options, sometimes combining the following options:

- Employing their own health-services staff. For example, school staff may include registered nurse(s) and/or other school health personnel (such as an LPN, health aide or paraprofessional, and/or secretary) who serve the entire school population or possibly only the children with special health-care needs. (See Appendixes A and B for sample position descriptions for a school nurse and a school health paraprofessional.)
- Contracting with the local health department (LHD) for public health nursing services. The LHD may serve the general school population or those students with special health-care needs, or it may provide specific health services such as communicable disease control and prevention.
- Contracting with hospitals, clinics, private home-care agencies, or cooperative educational service agencies (CESAs) for the services of a registered nurse(s). This model, too, may provide services to the general student population or to those students with special health needs.
- Provide or contract for the provision of school-based primary health-care services. The model is available in select urban school districts.

Figure 11

School Nurse Certification Requirements

(1) Degree Requirements:
The candidate for school nurse certification shall be a registered nurse in Wisconsin and shall meet one of the following requirements:

(a) An approved baccalaureate degree program in school nursing which includes the professional education requirements in sub. (2) and a school nursing practicum for at least 6 semester credits.

(b) A baccalaureate degree in nursing or a 3-year nursing diploma earned prior to June 30, 1975; be presently employed by or for a school board; have completed 3 years of experience in school nursing within the 5 years immediately preceding application for the license; had have completed either the 12 semester credits required under sub. (2), or be certified as a public health nurse and have completed at least 6 semester credits from the list of subjects in sub. (2).

(2) Professional Education Requirements:

(a) Three semester credits in human growth and development throughout the life span.

(b) Nine elective semester credits distributed among at least three of the following areas:

1. Sociology
   - a) Social Psychology
   - b) Child Welfare
   - c) Sociology of Education
2. Philosophy
   - a) Philosophy of Education
   - b) Philosophical Issues in Education
   - c) Philosophical Conceptions of Teaching and Learning
   - 4) Philosophy of Health Education
3. Psychology
   - a) Human Abilities and Learning
   - b) Educational Psychology
   - c) Psychology of Learning
   - d) Psychology of the Exceptional Child
   - e) Learning Processes in Children
4. Special Education
   - a) Health Problems of the Exceptional Child
   - b) Psychological Appraisal of the Physically Handicapped
   - c) Speech Correction
   - d) Guidance of Exceptional Children
5. Other Electives
   - a) Individualizing Instruction
   - b) General Curriculum
   - c) Problems and Materials in Health Education
   - d) Principles of Health Education
   - e) Guidance and Counseling
   - f) Reading and Language Arts

(3) Academic Specialization:

(a) An emphasis on pediatrics in ambulatory and community settings within the academic program is recommended.

Note: For applicants in an approved baccalaureate degree program in school nursing, a discrete course in reading is required.

Source: Wis. Admin. Code PI 3.51, School Nurse–75.

School districts should examine the health-service needs of the total student population to determine safe and appropriate staffing patterns.

According to the generally accepted guidelines by the American Nurses Association (ANA) and the National Association of School Nurses (NASN), the recommended full-time nurse-to-student ratio is:

- 1:750 in general school populations,
- 1:225 in mainstreamed populations, and
- 1:125 in populations of severely or profoundly disabled students.

In addition to the population groups noted above, other population groups can make unique demands on school nurses. (See Appendix C, "Sample District Allocation of School Nurse Hours.") These populations include students

- in early childhood;
- classified as "at risk";
- from low-income families;
- with special educational needs; and
- with physical, psychological, and social problems.

Consistent with the guidance of ANA and NASN, the Wisconsin Board of Nursing (1992) recommends nurse-to-student ratios that take into consideration the quality and complexity of the health needs of students, the availability of nurses and assistive personnel to provide care, and the need to ensure adequate supervision of assistive personnel. Administrative personnel should consider their own liability in observing and supporting safe nurse-to-student ratios.

Since student health issues now have a far greater impact on the educational mission of the school than ever before, school nurses and other school staff members must work cooperatively in addressing such issues. To help school nurses and others coordinate such efforts, Figure 12 offers readers an overview of "School Personnel Roles and Activities." (See Appendixes D and E for much-expanded version of both the school nurse's and school personnel's roles and activities.) It is recommended that school districts develop policies and procedures regarding school health services including nursing care. Job descriptions should clearly delineate roles, responsibilities, and lines of authority and, for professional personnel, should be based on standards of practice for their particular profession.

Roles and Standards

The mission of the school nurse is (1) to help students participate fully in their learning and feel safe in securing the health care that they need and (2) to prevent, remove, or modify conditions that interfere with academic achievement. While nurses may work under any number of service-provision models, school nurses generally

- establish and maintain a school health-service program;
- manage care for the health and illness needs of individuals in the school setting;
- develop and implement individualized health plans for students;
- collaborate with others inside and outside the school setting—including personnel and parents—to assess, plan, implement, and evaluate school health programs and activities;
- educate students, families, and groups to help them achieve optimal health;
- participate in peer review and other types of evaluation to ensure high-quality nursing care for students and staff;
- seek opportunities for continuing education and professional development;
- partner with other community members to assess, plan, implement, and monitor the provision of school and community health services; and
- advance the nursing profession through innovations in theory, role, practice, and participation in research.

The roles of school nurses as manager, provider, counselor, and educator were first described by the American School Health Association and later refined by Susan Wold in *School Nursing and Framework for Practice* (1981). Evolution of the school nursing roles continued with the work of the American Nurses Association (ANA) sponsorship of a task force with broad representation of national nursing organizations; its work resulted in the 1983 publication of *Standards of School Nursing Practice*.

The National Association of School Nurses (NASN), working with the ANA and the Commission on Teacher Credentialing in California, modified the language in *Standards of School Nursing Practice* and nested the standards within a framework of six nursing-role concepts described in its *School Nursing Practice: Roles and Standards* (Proctor, Lordi, and Zaiger, 1993). NASN developed a corresponding illustration (Figure 13) relating the nursing role concepts with the standards of school nursing practice.

School Personnel Roles and Activities

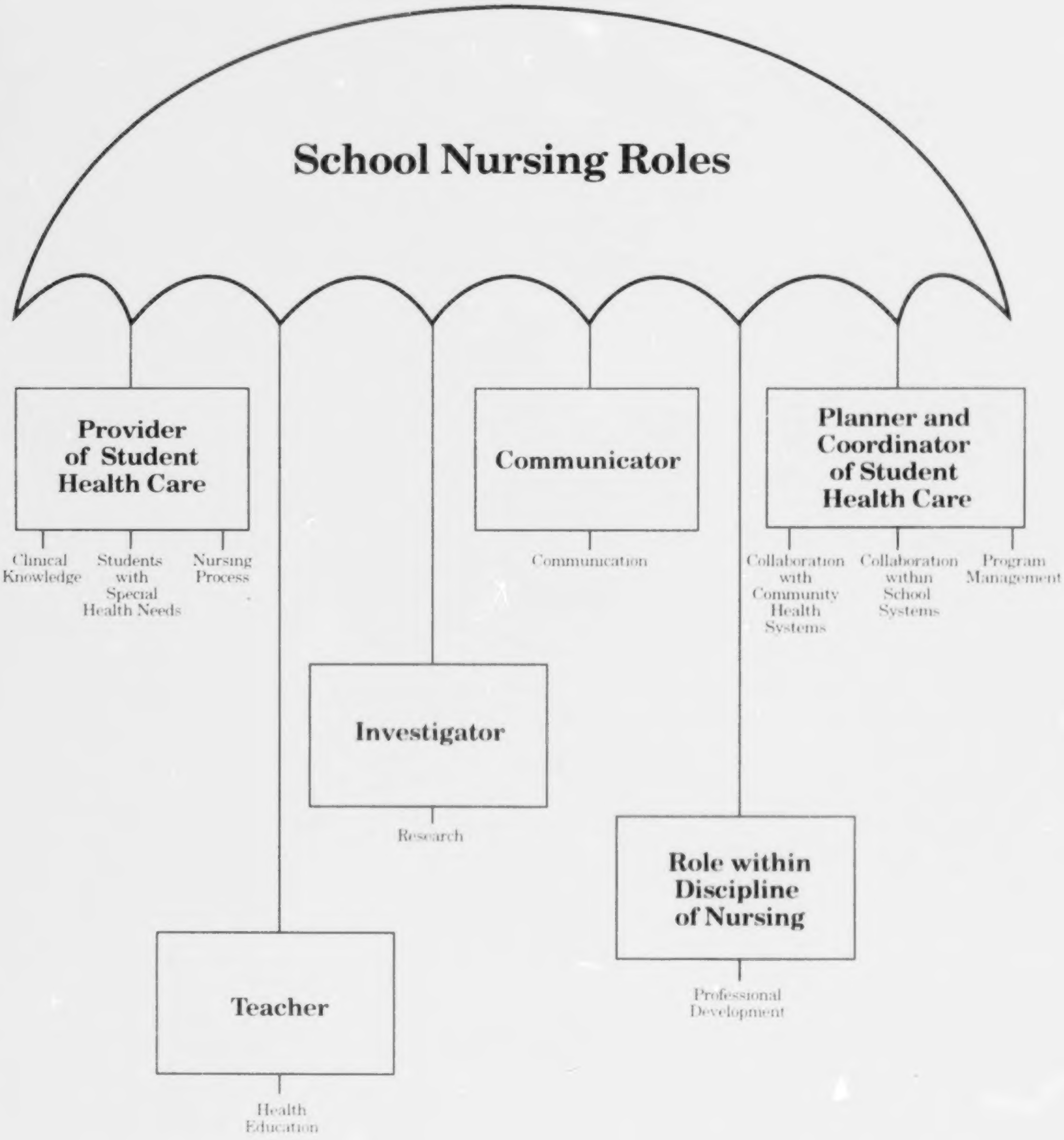
Title and Description	Legal Requirements	Health-Related Activities	Related Nursing Role
Classroom Teacher A licensed professional school employee whose work includes the exercise of any educational function for compensation, including instructing students or administrating, directing, or supervising any educational activity.	*General Requirements:** PI 3.05—General requirements for licensure PI 3.05(11)—Minimum grade point average of 2.75 on a 4.0 scale or standing in upper 50 percent of the class PI 3.05(12)—Initial professional education program is a baccalaureate degree in which at least one-third of semester hours are in the area of general education PI 3.05(13)(a)(b)(c)—Specific licensure requirements for early childhood, elementary, middle, secondary, and K-12	• Teaches health curriculum • Identifies health and safety concerns in the classroom and school • Identifies students with special health-care needs • Refers students to appropriate person such as student-service providers when health and education concerns arise • Implements health-related programs for specific children • Participates in IEP meetings • Interacts directly with students and parents	Teacher Planner and coordinator of school health care Provider of school health care Communicator Investigator
School Health Paraprofessional An individual who, under the supervision and delegation of a registered nurse, provides nursing services.	School Health Paraprofessional Training Course** through a technical college or other nurse aide training program, successfully completed prior to or within one year of employment.	Under the direction of the school nurse, • provides basic first aid care • assists with monitoring, reporting, and documenting • makes appropriate follow-up referrals to school nurse • assists with school health screenings • helps maintain immunization and other student health records • helps maintain the school health office • administers medications and carries out nursing procedures • facilitates communication among parents, students, school personnel, and the school nurse • maintains confidentiality	Provider of school health care Communicator

* Position requirements per Wisconsin Department of Public Instruction

** Recommended by the U.S. Public Health Service, Bureau of Health Professions, 1989

Figure 13

National Association of School Nurses School Nursing Roles and Standards


School Nursing Roles
Provider of Student Health Care
Clinical Knowledge
Students with Special Health Needs
Nursing Process
Communicator
Communication
Planner and Coordinator of Student Health Care
Collaboration with Community Health Systems
Collaboration within School Systems
Program Management
Investigator
Research
Role within Discipline of Nursing
Professional Development
Teacher
Health Education

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The NASN model contains common pairings between six primary roles and 10 distinct standards. The NASN pairings reveal the organization's multifaceted and challenging, though practical approach to providing health care in the educational setting. While the model focuses on common pairings, as one might expect, nurses may find in practice that their work reflects a hybrid of two or more pairings.

Provider of Student Health Care

Provider of Student Health Care pertains to a body of clinical knowledge necessary for school nursing practice and provides a framework for critical thinking regarding the direct and indirect provision of services to students, families, and staff members. The three standards constituting this role include: (1) Clinical Knowledge, (2) Nursing Process, and (3) Students with Special Health Needs.

Communicator

The role of interpersonal communication is a skill inherent to all facets of school nursing practice. For example, as a child health advocate, the school nurse needs to bridge the health and education systems, often acting as an interpreter for the student, family, and school staff. This role relates to Standard (4)—Communication.

Planner and Coordinator of Student Health Care

As *Planner and Coordinator of Student Health Care*, the nurse delivers services to individual students and student groups by effectively applying skills in networking, collaborating, coordinating, and managing programming. The services interact with schoolwide and/or communitywide health programming and facilitate the delivery of services through coordination and management. The related standards include: (5) Program Management, (6) Collaboration within School Systems, and (7) Collaboration with Community Health Systems.

Teacher

In the role of *Teacher*, nurses develop and implement health education strategies that enable students, their families, and school staff to acquire the knowledge and skills necessary to promote personal, family, and community health. This role relates to Standard (8)—Health Education.

Investigator

The knowledge and skill base for school nurses is derived from theory, principles, and practice of pediatric and family health care; child growth and development; public and community health; and education. To effectively respond to the health needs of students, their families, and the school program, mastery of the knowledge and skill base is essential.

The role of *Investigator* focuses on using data to understand current and emerging threats to the health of the student population. The school nurse observes patterns of change in individuals, groups, and systems, noting and communicating both informal and formal findings. This role relates to Standard (9)—Research.

Discipline of Nursing

The *Discipline of Nursing* role encompasses issues delineating and clarifying the role of the nurse and matters relating to quality of care. It also examines professional-practice issues related to nursing in schools and encourages

- the development of innovative practice,
- a commitment to professional conduct,
- professional evaluation, and
- continued professional growth.

This role relates to Standard (10)—Professional Development. (See Figure 14 for an overview of activities, standards, and legislation which may bridge gaps between professional standards and practice. See Appendix D for related information.)

In addition to the standards of practice, other important guidance is provided in the professional code of ethics. (See Appendix F for a Nurse's Code of Conduct from the American Nurse Association Code for Nurses and the National Association of School Nurses Code of Ethics.)

Delegation

Across the state and the nation, students with special health-care needs are attending school and placing new demands on school districts. Local school boards must provide sufficient staff and resources to ensure a level of school health services previously not necessary or required. Though cited in the previous chapter, the reasons bear repeating:

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Figure 14

Sample Nursing Role: Communicator

Suggested Objectives	Desired Results
Uses effective expressive and receptive verbal skills and clear, concise written communication.	Student, family, school administrators and personnel, and others, as appropriate, are informed about current health status and the interventions taking place within the school setting.
Develops and maintains an effective system of information storage, retrieval, and analysis.	Evidence of verbal or written reports exist which reflect current nursing theory, practice, and/or research.
Develops and implements systems to communicate regularly with staff, students, parents, and others to address health-related education needs.	Meaningful relationships exist with students, school staff, and community providers. Health-service and health-status information is collected, communicated, and maintained within the confidentiality parameters set forth in federal and state law and local school district policy. Annual health services and miscellaneous reports are developed and presented to school administrators and others, as appropriate, to provide continuity and accountability of the health-service program. Documentation exists of the establishment, review, and revision of school district policies and procedures. Nursing care plans are developed and revised based on the health and behavioral changes identified in the evaluation.

Related Standards, Laws, and Policies

American Nurses Association (ANA) Standards of School Nursing Practice (1983)
ANA Code for Nurses with Interpretive Statements (1985)
National Association of School Nurses (NASN) Code of Ethics with Interpretive Statements for the School Nurse (1990)
NASN School Nursing Practice: Roles and Standards (1993)
Wis. Stat. 441 (WI Nurse Practice Act)

- changes in the health-care system resulting in the treatment of children with complex medical problems in out-patient community settings rather than in-patient settings
- advances in medical technology creating greater mobility of those who are technology dependent
- federal requirements ensuring students with health-related disabilities have access to appropriate educational programs and related services in the least restrictive environment
- parents' expectations regarding their children's rights to health care in the school setting.

These trends raise issues regarding educational placement and maintenance of student health and student safety as well as issues of school and professional accountability. In making decisions about the educational placement of students with special health-care needs and the provision of nursing services, two particular concerns emerge: (1) the health and safety of the students and (2) the liability of all involved parties (that is, the school board, school administrators, school staff, and the school nurse).

School administrators are legally responsible for the safety of all students, including the provision of required health services by qualified staff.

Legal Considerations

Using nonqualified staff risks harm to the students. In addition, nonprofessional school health personnel are liable for their actions if they practice nursing or medicine without a license.

The practice of licensed professional health-care providers—such as physicians, nurses, physical therapists, and occupational therapists—is governed by the statutes and rules of the Licensing Board. These statutory requirements provide a basic framework of practice to ensure a level of professional competency and to protect the public from unqualified practitioners.

Registered nurses (RNs) are the most frequently available professional health-care providers in schools. What follows is a discussion of delegation of care by a registered nurse to school staff who are not professional health-care providers:

Delegation is "transferring to a competent individual the authority to perform selected nursing tasks in a selected situation. The nurse retains accountability for the delegation" (National Council of State Boards of Nursing, 1995). Registered nurses are professionally responsible by law to make decisions about which nursing-care activities may safely and legally be delegated to others and what their responsibilities are in the process of providing care or delegating care to others. When a RN delegates a nursing act to a licensed practical nurse (LPN) or less-skilled person, the RN must comply with licensing standards adopted by the Board of Nursing. Wis. Admin. Code N6.03 specifies the following standards for delegating, supervising, and directing delegated nursing acts:

- Delegate tasks commensurate with educational preparation and demonstrated abilities of the person supervised.
- Provide direction and assistance to those supervised.
- Observe and monitor the activities of those supervised.
- Evaluate the effectiveness of acts performed under supervision.

The critical concept in delegation is the legal principle of *respondeat superior*—that when the RN determines that someone not licensed to practice nursing can safely provide a selected nursing activity or task and delegates that activity to the individual, the RN remains responsible and accountable for the care provided. *It is important to note that delegated tasks cannot be redelegated by the delegate.*

From a management point of view, a school administrator may suggest who will be assigned to assist with nursing care; however, only the nurse may delegate nursing acts to licensed practical nurses and other less-skilled school health personnel. The RN is ultimately responsible for making the delegation decision in each individual situation, even if a physician or other health professional states or "orders" that such care should be provided by nonlicensed school health personnel. The only exception is if the physician or other professional takes full responsibility for the delegation, training, ongoing monitoring, and supervision of nonlicensed school health personnel. In certain situations a question may arise about whether a health-care procedure is the practice of medicine or nursing. It is prudent for a school nurse and the child's primary-care physician to agree on the decision based on the current health status of the child and the nature of the care provided.

Parents

While parents sometimes believe that they should determine the level of care required for their child, it is critical for parents to distinguish between their role as caretakers at home and the role of those who are employed as care providers in the school. Among other variables,

- the school setting is an environment entirely different from the home,
- school personnel have different responsibilities in their positions and different obligations under the law,
- school personnel change positions,
- parents do not have the authority in the school to make administrative decisions or to supervise school staff.

In addition, while the Wisconsin Nurse Practice Act (Wis. Stat. 441.115) makes an exception for friends or members of the family who provide nursing care to a child, this exception to the licensure provisions is not limited to the home and may empower family members or friends to provide care in the school. However, they may not extend that right to other individuals in the school. In situations where family members or friends provide care in the school setting, responsibilities of all who provide care should be documented.

One cannot assume that the school nurse has accountability for all nursing care provided in the school (Wisconsin Regulatory Digest, 1992) if this exception is exercised by family members and friends in the school setting. It remains essential that the family, school nurse, school team, and other health-care providers work in collaboration to plan and provide the student with safe, effective care in an environment that is not only least restrictive but also safe for all students and staff.

Delegating Nursing Acts

A 1995 position paper of the National Association of State School Nurse Consultants (NASSNC) entitled "Delegation of School Health Services to Unlicensed Assistive Personnel" provides guidance regarding the determinations a RN should make when delegating and supervising unlicensed school health personnel. In so doing, the RN

- verifies the necessary physician orders (including emergency orders), parent/guardian authorization, and any other legal documentation necessary for implementing nursing care;
- conducts an initial nursing assessment;
- based on assessment of the student, determines what level of care is required;
- determines the amount of inservice training required for individuals performing such nursing services and ensures such training is obtained;
- evaluates the competence of individuals who may be called upon to safely provide nursing services;
- provides a written care plan to be followed by the delegate;
- delegates the task of providing such services to those individuals, whether they be licensed or unlicensed school health personnel;
- determines the frequency and type of student reassessment necessary for ongoing safety and effectiveness;
- documents, supervises, and provides ongoing monitoring to evaluate the effectiveness of delegated nursing acts; and
- documents activities appropriate to each of the preceding nursing actions (see Appendix G, "Documentation of Delegation of Nursing Procedures.")

Additional Considerations

Following consultation with the student's family, physician, other health-care providers, school staff, and appropriate consultants, the RN may determine that the level of care required by the student cannot be safely provided under current circumstances in the school. In that event, the school nurse should refer the student back to the initial assessment team (building consultation team, accommodation team, individual educational plan committee, or other appropriate group) and assist the team/committee to (1) reassess the student's health and educational needs and (2) explore alternative options for a safe and appropriate program. If such a program is not designed and the student continues in an unsafe situation, the RN may want to consider the following NASSNC (1995) recommendations:

- Write a memorandum to one's immediate supervisor explaining the situation in sufficient detail, including recommendations for the safe provision of care in the school (or the reason the care or procedure should not be performed in the school) and the rationale to support the recommendation.
- Keep a copy of the memo in one's personal file.
- Allow the supervisor a reasonable period of time to initiate action to safeguard the student.
- If actions to safeguard the student do not occur, forward a copy of the memo to the following individuals, as appropriate: the district superintendent, the state board of nursing, the state school nurse consultant, and the division of special education at the U.S. Department of Education (if a special education student) or the Office of Civil Rights (if child is accommodated under Section 504).

Additional resources providing guidance related to issues of delegation include:

- DPI Bulletin 91.14. *The Delegation of Specialized Physical Health Care to Non-Professional Health Care Providers in the Schools* (1991)
- Wisconsin Board of Nursing. "Nursing Care in the Schools," in *Wisconsin Regulatory Digest* (November 1992)
- Joint Task Force for the Management of Children with Special Health Needs. *Guidelines for the Delineation of Roles and Responsibilities for the Safe Delivery of Specialized Health Care in the Education Setting* (1990)
- Unlicensed Assistive Nursing Personnel Task Force. *1995 Guidelines for the Utilization of Unlicensed Assistive Nursing Personnel.* Wisconsin Nurses Association (March 1995).
- National Council of State Boards of Nursing. *Delegation: Concepts and Decision-making Process* (1995)

Supervision and Training

For purposes of this publication, supervision means "the provision of guidance or direction, evaluation, and follow-up by the licensed nurse for accomplishment of a nursing task delegated to nonprofessional health care providers" (National Council of State Boards of Nursing, 1995). Supervision does not necessarily require the immediate presence of the supervisor at all times.

The term supervisor means a qualified school nurse, public health nurse, or licensed physician who directs the provision of health-care services. Supervisors are responsible for

- ensuring that the direct provision of specified procedures is assigned to persons who are qualified to perform them;
- exercising due professional judgment in specifying the type, level, and frequency of supervision required for each procedure; and
- informing the school administrator (and/or other school staff or the individualized education plan committee, if appropriate) of this determination.

Wis. Admin. Code 6.02 (6)(7) defines supervision in two ways:

- "Direct supervision means immediate availability to continually coordinate, direct and inspect at first hand the practice of another." The supervisor is physically present while a procedure is being administered, *or* the supervisor is in the same building as the person being supervised and is available for consultation and/or assistance.
- "General supervision means to regularly coordinate, direct and inspect the practice of another." While general supervision includes an on-site personal review of the individual's competence in performing the specialized physical health-care service and in maintaining the appropriate records, physical environment, and necessary equipment, it does not require the supervisor to be physically present while the procedure is administered. (Note: It is advisable, however, for the RN to be available for consultation by telephone.)

Conclusion

Professional roles and practice standards affect every decision that a school nurse makes, every action that a school nurse takes. As the chapters ahead focus on more specific elements of school nursing in Wisconsin, readers may wish to return to this chapter and its related appendices to review this fundamental information.

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Health Literacy 3

Introduction

The legal, professional, and practice issues that shape the school nurse's daily work are complex and often intricately interconnected with other individuals and organizations. Health promotion—a concept integral to the nursing profession and its education programs—has its place in Wisconsin schools.

The World Health Organization defines health as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity." Certainly, promoting such a complete state of well-being demands the involvement of people and organizations beyond the walls of schools.

When health promotion occurs successfully within the school, the result is health literacy, which health education professionals define as (1) the capacity of individuals to obtain, interpret, and understand basic health information and services and (2) the competence to use such information and services in ways that enhance health (Joint Committee on National Health Education Terminology, 1990). Health-literate students are well educated about personal, family, and community health. They are the healthy, successful, resilient learners depicted in the the Framework for Wisconsin Comprehensive School Health Programs (see Figure 1, page 2). Not only is health literacy equal in importance to other educational literacies (such as reading or science), but the goal of becoming health literate is consistent with the mission of nursing.

The purpose of this chapter is (1) to translate the broad aspects of health promotion into corresponding educational results related to health literacy and (2) to describe the role of the school nurse in promoting health literacy through educational initiatives. Using this chapter as a stepping stone—from which they should move on to acquire and carefully consider many of the cited resource materials— readers should strive to:

- know applicable state and federal regulations and district policies that impact on health literacy and health education in schools;
- understand the National Health Education Standards (1995) and Wisconsin Health Education Standards (1997) as well as other pertinent publications;
- work in cooperation with school administrators and staff members, parents, and health-related community agencies to establish policies that create healthy learning environments that support youth development, to develop and enhance school health education programs, and to integrate health concepts across other curricular areas; and
- embrace the teaching role within nursing practice to nurture the development of health-literate individuals and groups by
  - — using health-service activities as direct and indirect learning opportunities;
  - — providing health-related inservice programs for school staff, parents, and community groups;
  - — participating in classroom health instruction; and
  - — providing health information and resource materials.

To help readers achieve those goals, this chapter will address:

- national and state health education standards,
- legal considerations, and
- the school nurse's role in health education.

Health Education Standards

National and state standards for health education closely parallel each other in both content and language, which appears to suggest widespread agreement as to the academic importance of health literacy. The authors of the standards have identified four personal characteristics of a health-literate person. The health education standards issued in 1995 by the Joint Committee on National Health Education Standards, describe a health-literate person as:

- a critical thinker and problem solver,
- a responsible and productive citizen,
- a self-directed learner, and
- an effective communicator.

As *critical thinkers and problem solvers*, health-literate people identify and creatively address health problems and issues at multiple levels, ranging from personal to familial to communal and beyond. They use a variety of sources to gain access to the current, reliable, and applicable information required to make sound health-related decisions.

As *responsible and productive citizens*, they recognize their obligation to ensure that they, their family, and their community are kept healthy, safe, and secure so that all citizens can experience a positive quality of life.

As *self-directed learners*, they possess a command of basic information regarding health promotion and disease prevention. They apply that knowledge in interpersonal and social relationships, learning about and from others to enhance their own health.

And as *effective communicators*, health literate people analyze, develop, organize, and convey beliefs, ideas, and information about health in a variety of ways. They seek to develop and articulate positions, policies, and programs that are in the best interest of society and are intended to enhance personal, family, and community health.

National Standards

As previously noted, the Joint Committee on National Health Education Standards (NHES, 1995) published findings from a two-year study which included input from health and education professionals, parents, and community members. According to their publication *Achieving Health Literacy*, "Health education in schools is essential to enable students to acquire the knowledge and skills to promote health. Students who have health knowledge and skills have better health status and contribute to the nation's competitiveness by working more effectively; missing fewer days from work due to injury and illness; using fewer medical services due to prevention or delayed onset of disease; and reducing use of health insurance benefits."

The standards reflect a state-of-the-art approach to school health education and serve as a model for schools to review as they work to create instructional programs that will enable students to achieve academic success as detailed in Public Law 103-227, which can be found in the informational booklet, *Goals 2000: Educate America Act* (American Cancer Society, 1995), and achieve the health goals described in *Healthy People 2000: National Health Promotion and Disease Prevention Objectives* (U.S. Department of Health and Human Services, 1990). As one might expect, the NHES are conducive to the the six professional roles of the school nurse (see Figure 15) and the professional performance standards outlined by the National Association of School Nurses (NASN).

The NHES and the NASN standards call for parallel actions by students and school nurses. For example, as students learn health-promotion and disease-prevention concepts, the school nurse may model the teacher role by offering and discussing health education materials or by providing formal health instruction to individuals and groups. The ultimate goal of each of these efforts is to encourage and, whenever possible, facilitate effective student self-care.

Wisconsin Standards

Wisconsin's *Academic Content and Performance Standards for Health Education* (WDPI, 1997) closely parallel the national standards. During the development of the national standards, thousands of Wisconsin health and education professionals, legislators, businesspeople, parents, and community members reviewed and offered feedback on drafts of the proposed state standards.

In concert with federal standards, Wisconsin's standards provide a solid foundation for effective health education programs in schools and communities; they are, in large measure, reinforced and supported by the state health goals (Wisconsin Department of Health and Social Services, 1990). With the power of state and federal regulations behind them, these standards have the potential of achieving significant advances in health education to the benefit of hundreds of thousands of Wisconsin students and the millions of people who make up their families and communities. This is already being accomplished and will grow in its effectiveness as nurses and educators in Wisconsin embrace health education and strive to present it in accessible, strategic ways to Wisconsin students, families, and others in communities served by the state's 426 public school districts.

Legal Considerations

Five state statutes and corresponding regulations provide the primary foundation for health education in Wisconsin schools:

- Wis. Stat. 115.35–Health Problems Education Program
- Wis. Stat. 118.01(2)–Educational Goals and Expectations
- Wis. Stat. 118.019–Human Growth and Development Instruction
- Wis. Stat. 118.33(1)–High School Graduation Standards
- Wis. Stat. 121.02 (e), (i), (j), (k), (l), and (p)–School District Standards

When accepting categorical grants or other funds administered by the Wisconsin Department of Public Instruction, school districts must also abide by a number of additional statutes regarding the development of comprehensive programs, including:

- Wis. Stat. 115.362–Youth Alcohol and Other Drug Abuse
- Wis. Stat. 115.365–Suicide Prevention
- Wis. Stat. 115.368–Protective Behaviors
- Wis. Stat. 115.92–School-age Parent

A complete listing of all relevant state statutes and corresponding administrative rules is contained in Appendix H, "State and Federal Laws Related to School Nursing."

Educational Goals and Expectations

Wis. Stat. 118.01(2) provides school districts with educational goals and expectations relating to:

- academic skills and knowledge
- vocational skills
- citizenship and
- personal development

Figure 15

National Health Education Standards and the Nursing Role

The student will	*The nurse models the*
1. comprehend concepts related to health promotion and disease prevention.	teacher role
2. demonstrate the ability to gain access to valid health information and health-promoting products and services.	investigator role
3. demonstrate the ability to practice health-enhancing behaviors and reduce health risks.	teacher role provider of health care role
4. analyze the influence of culture, media, technology, and other factors on health.	communicator role investigator role
5. demonstrate the ability to use interpersonal communication skills to enhance health.	communicator role
6. demonstrate the ability to use goal-setting and decision-making skills to enhance health.	planner and coordinator of health care role investigator role
7. demonstrate the ability to advocate for personal, family, and community health.	communicator role teacher role

The personal development mandates have perhaps the greatest impact on health educators. They outline expectations that are a natural part of any comprehensive school health education program, including:

- decision-making skills;
- knowledge of the human body and means by which to maintain standards of good health and wellness;
- appreciation of creative/artistic expression;
- the development and commitment to personal ethics, morals, and goals; and
- safety promotion.

School District Standards

Wis. Stat. 121.02 (e), (i), (j), (k), (l), and (p) and corresponding administrative rules seek to ensure maintainence of minimum standards, in both primary and secondary schools, relating to providing:

- guidance and counseling services;
- safe and healthful facilities;
- health instruction based on a comprehensive, written K-12 curriculum that includes the areas defined in Wis. stats. 115.35(1) and 118.01(2); and
- high school graduation standards (see below).

Each standard and its related administrative rule are denoted by letters which correspond to rules/expectations readily recognized by Wisconsin educators. For example, Standard (a) refers to licensure, while Standard (e) relates to guidance and counseling. It is important that nurses and educators understand that these citations differ from the national and state standards described in the previous section and that the administrative rules include a significant amount of information related to each standard which cannot be covered in this publication. Thus, it is in the best interest of nurses and educators to personally review such material.

Health Problems Education

Wis. Stat. 115.35 addresses the design of integrated programs to educate students about critical health problems, including but not limited to:

- controlled substances
- alcohol abuse
- mental health
- sexually transmitted diseases (including AIDS)
- human growth and development
- related health and safety topics

Human Growth and Development

Wis. Stat. 118.019 encourages school boards and districts to provide students in grades K-12 instruction related to human growth and development. Topics may include but are not limited to:

- self-esteem
- responsible decision making
- personal responsibility
- human sexuality
- family life
- parenting skills
- protective behaviors

When developing human growth and development curricula, schools must appoint an advisory committee composed of parents, teachers, school administrators, students, health-care professionals, members of the clergy, and other residents of the school district. The advisory committee must then review the curriculum at least every three years.

Though the purpose of such courses is to undergird a family's efforts to support the healthy development of young people, the content of such programs may be deemed by a particular family to be inconsistent with their deeply held religious or other moral beliefs. Recognizing the importance of a family's right to make such decisions without interference or undue influence from schools or the state, Wisconsin has chosen to make student participation in human growth and development courses voluntary. Specifically, no student may be required to participate in human growth and development activities or instruction if a student's parent(s)/guardian(s) files a written request with the teacher or school principal for exemption from such a class, portion of a class, or class activity.

To help families make decisions regarding such instruction, state law requires districts to provide an outline of the curriculum to each student's parent(s)/guardian(s) as well as information regarding how the parent may inspect the complete curriculum and instructional materials.

Graduation Requirements

Wis. Stat. 118.33(1) requires students in grades 7-12 to earn one-half (0.5) credit of health education in order to graduate.

The Role of the Nurse in Health Education

School nurses coordinate or assist in developing and revising health education curricula by

- identifying human and material resources to support the curriculum;
- collaborating with teachers, student-services personnel, and other support staff members to encourage integrating the school health education program with other interrelated and interdependent curricula, school programs, and services;
- collaborating with public and private community health agencies to promote health literacy;
- promoting continuity through all grade levels and in special populations, such as students with disabilities or students with limited English proficiency; and
- playing an integral role in the evaluation of the school health education program.

While formal health instruction should follow a planned, written, comprehensive curriculum offered by a certified teacher, students require more than formal instruction to achieve health literacy. People other than the classroom teacher are capable and appropriate providers of health education. The most important provider of health education is the student's parents or guardians. Anyone whose interactions with students help maintain student health, prevent disability, and promote well-being plays a role in building the capacity of students to become health literate. Although this includes everyone from the driver on the bus to the principal, the school nurse remains the focus of this book.

When developing, revising, or enhancing the health education curriculum, the school nurse works with a variety of people to determine the learning needs of students and staff members. A needs assessment may be helpful to determine what individuals or groups within the school community need or desire to learn. A number of resources are essential references in assessing curriculum and development needs, including:

- the U.S. Department of Health and Human Services publication *Healthy People 2000* (1990) and subsequent documents, and
- the Wisconsin Department of Health and Social Services publication *Healthier People in Wisconsin: A Public Health Agenda for the Year 2000* (1990) and subsequent documents.

Both identify emerging health issues and their corresponding educational goals, which easily translate into health education objectives. In addition, the school nurse should acquire the following resources:

- *Goals 2000: Educate America Act* (American Cancer Society, 1995),
- *Wisconsin Developmental Guidance Model: A Resource and Planning Guide* (WDPI, 1997),
- *Wisconsin's Academic Content and Performance Standards for Health Education* (WDPI, 1997),
- *Wisconsin's Academic Content and Performance Standards for Physical Education* (WDPI, 1997), and
- *Wisconsin's Academic Content and Performance Standards for Family and Consumer Education* (WDPI, 1997).

The eighth NASN standard of practice requires school nurses to help students, families, school personnel, and the broader community to achieve optimal levels of health and wellness through appropriately designed and delivered health education. When looking at how to apply this standard in a practical way, it may aid readers to connect the *design* of health education to indirect nursing services and the *delivery* of health education to direct nursing services. Indirect services occur through or with the classroom teacher or other educator, while direct services allow nurses the opportunity to take advantage of "teachable moments" with the students, often outside the formal classroom.

Indirect Nursing Services and Health Education Design

The school nurse can enrich health instruction by designing health-related classroom activities. With suggested topics from *A Guide to Curriculum Planning in Health Education* (WDPI, 1985) and the priorities that emerge from a needs assessment as a foundation, the nurse and teacher may cooperatively plan specific opportunities for classroom participation.

In addition, the school nurse may offer minicourses or support groups for students on such topics of concern as weight control, skin care, and management of asthma or diabetes. The same topics may provide the basis for staff development programs. Where the health curriculum is so full it does not allow for in-depth examination of specific needs and concerns, the school nurse may choose to develop programs which include curriculum enrichment materials and small-group discussions.

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In whatever capacity they serve the health education program, in order to be effective in the school environment, school nurses need to be skilled in educational management strategies, including:

- determining student readiness for learning;
- developing and delivering a lesson plan and units based on student needs, interests, and levels of growth and development;
- communicating to students a lesson's objective and purpose;
- evaluating the lesson plan and students' classroom experience to assess their understanding of the material; and
- promoting higher-level thinking.

Group Health-Literacy Activities

From the youngest students in regular classes to an ad hoc committee of parents concerned about a contemporary health issue, from individuals to large groups, there are hundreds of people a school nurse can educate and influence throughout the school year. Working with a group can ease a heavy student-to-nurse ratio, reaching a far greater number of students than individual sessions would allow. Perhaps most beneficial is the opportunity for discussion that comes with group activities, allowing participants with unique experiences to share and ask questions and making for a broader, more inclusive and in-depth discussion.

Whether as the primary facilitator or as a cooperative partner, the school nurse can educate and influence others using a variety of instructional models in numerous settings.

Elementary School

A senses unit, which integrates vision and hearing screening with a scientific unit on the senses, offers an opportunity to integrate health-care services with instruction on related anatomy and physiology. In so doing, nurses can help students better understand their bodies and assessment procedures and help them understand and implement vision and hearing protection strategies. Such units can also enhance compliance with vision and hearing referrals.

Middle School

A health-consumer unit might offer students an understanding of and access to available health-care resources, including physical and emotional health exams. This curricular unit could include:

- a review of the components of the health history and physical exam,
- a practice session, and
- demonstrations of tools and equipment used in physical exams.

A possible homework assignment could have students obtain a family health history and develop a personal health plan. The unit could conclude with a practice session where community health providers come to school and students practice their new health-consumer skills in specific role-playing situations.

Among the possible benefits of such an effort might be:

- an increased knowledge of anatomy and physiology,
- an appreciation of and positive participation in the physical examination process,
- an awareness of the impact that self-care activities have on personal health,
- compliance with health-care assessments and immunization, and
- enhanced health-consumer skills.

High School

In a physics or driver education class, students could conduct experiments to demonstrate the distribution of mechanical (kinetic) energy on the occupant of a motor vehicle during a crash. A model car could be crashed into a barrier while students take measurements of the force exerted at different points in the car.

To help students better understand the value of protective equipment, the teacher could challenge them to create a protective carrier for a raw egg and drop the egg in its carrier from a significant height (or place it in different parts of the crash car) to acquire "real-life" feedback of the effectiveness of their chosen method of protection.

Finally, students can be challenged to extrapolate from such experiments ideas regarding how a similar impact might affect the human skull when protected by their designed device during a bicycle or automobile collision.

Cross-Disciplinary Visits

While many of a nurse's health-care education efforts will be implemented in a health education class, opportunities may arise for them to be implemented in other settings.

For example, a creative nurse may find opportunities to partner with classroom teachers to link a particular health education lesson to that teacher's area of expertise.

- In a physics class, the nurse can relate the causes and cures for hypertension and poor circulation to pressure; lumens or tubes can be understood through lessons on hypertension and the principles of good circulation.
- With a history teacher, the nurse can discuss food preservation and related communicable diseases by tying the health lesson to stories about the emigration of British settlers to the "New World" and the problems of disease in a "pre-technological" era.

These creative links between health and other curricular areas, which require thoughtful development of creative classroom partnerships by the school nurse, can provide students with an engaging, memorable learning experience.

Employee Health Promotion and Wellness

The school nurse provides leadership in developing, implementing, and evaluating staff health promotion and wellness programs. These may include:

- *Cardiopulmonary Resuscitation (CPR) Training Programs.* This program would increase the number of individuals who are prepared to respond to cardiovascular/respiratory emergencies in the school setting and at home. It promotes a safer environment for students and staff members by increasing the likelihood of a successful health outcome following a cardiovascular/respiratory emergency. (For more information, see Chapter 9, "Emergency Services.")
- *Bloodborne Pathogen Inservices.* Such programs increase staff members' awareness of the potential risks of communicable-disease transmission. Such training has the potential for decreasing incidents that involve the transfer of body fluids between two or more individuals and exposure to or spread of communicable diseases. (For more information, see Chapter 4, "Communicable Disease Control and Immunization.")
- *Health Risk Appraisal, Screening, and Intervention Programs.* Employee health and wellness programs could have a significant impact on the emotional and physical health of staff members. Measurable indicators which may demonstrate the success of such efforts include improvement in: fitness, blood pressure, cardiovascular health, sense of well-being, attendance, productivity, and the effective use of health insurance resources.

Involving the school nurse in health literacy and instruction among individuals and groups will vary, depending on:

- the school district's administrative structure,
- community resources,
- the role of the school nurse in a given school,
- the nurse's time constraints,
- nurse-to-student ratios, and
- the number of schools a nurse may be assigned to serve.

Individual Health Literacy Activities

School nurses provide individualized health education each time they provide direct services to individual students and staff members. Through such contacts/discussions, those served can acquire knowledge and make decisions about what to do when problems arise. Such incidental health education may be offered while

- attending to a student's laceration, during which a nurse may offer instruction on injury prevention, self-care, and the risk of secondary infections (see Chapter 9, "Emergency Services");
- monitoring the use of a metered dose inhaler, during which the nurse may talk with an asthmatic student about coping strategies and management of chronic health problems (see Chapter 5, "Medication Administration"); or
- helping a student with a bloody nose, during which the nurse might instruct the student (and perhaps a friend who accompanied the patient to the nurse's station) on related first aid techniques as well as risks related to the transfer of bloodborne pathogens and the spread of communicable diseases at home, school, and in the community (see Chapter 4, "Communicable Disease Control and Immunization").

In each case, as well as dozens of others, the nurse has a unique, personalized opportunity to instruct students on issues of prevention, self-care, first aid, and related topics and to make a meaningful case for how attention to such matters will enhance students' academic and recreational achievement and overall well-being.

While it is a challenge to teach health and wellness strategies to students and staff members, it is equally an admirable challenge to work toward broadening the parameters which often limit such efforts. The incorporation of such strategies as those outlined above in the daily work of the school nurse is a small step toward creating a more health-literate body of students, staff members, and community residents.

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Communicable Disease Control and Immunization

4

Introduction

The specialty of school nursing grew as part of public health nursing in the early 1900s, mainly as a means of identifying and treating students with serious communicable diseases and of informing educators, parents, and children about how to control infectious and contagious diseases.

Infectious diseases are illnesses caused by specific germs: viruses, bacteria, fungi, or parasites. Infectious diseases that can be spread from one individual to another are called contagious or communicable diseases. Communicable diseases are one of the major problems contributing to both student and staff absence as well as the discomfort associated with a given affliction.

Some of the diseases children have now are the same as those seen in the early part of the 20th Century, and some are new and different, such as HIV or hepatitis. While responsibility for care of the individual student rests with the family and their source of medical care, the school nurse remains responsible for identifying communicable illnesses in the school and ensuring their treatment. Although that responsibility is shared with students, staff, and the greater community, school nurses must be leaders in promoting infection control in schools as well as in providing information to educate students, parents, and staff about communicable disease prevention.

While the preceding chapter focuses on health promotion and disease prevention through education (fostering health literacy), this chapter focuses primarily on the *practical* applications of disease prevention strategies, such as immunization, which is undergirded by specific legislation mandating schedules and corresponding administrative procedures. This chapter also describes the measures schools can take to prevent the spread of communicable diseases in the school setting, including simple steps like hand washing or the temporary exclusion of individuals from the school setting.

Using this chapter as a stepping stone from which they should move on to acquire and carefully consider many of the cited resource materials, readers should strive to

- understand state statutes relating to immunization of students and the timeline for notifying parents and for reporting to the local health department and district attorney.
- be aware of recommended and required immunizations for students and staff members.
- serve as a resource for parents seeking services from community health-care providers.
- explain the risks and benefits of immunization.
- use appropriate forms to collect immunization data, including the month, day, and year of all immunizations.
- evaluate immunization histories in light of state laws and recommendations relating to immunizations.
- understand state statutes relating to communicable diseases and how they pertain to students and staff members.
- review school district policies related to exclusion from school and to communicable disease control and prevention.
- monitor students and staff members for communicable disease symptoms and outbreaks.

- understand and follow Occupational Safety and Health Administration (OSHA) bloodborne pathogen standards.
- educate staff members about universal precautions.
- ensure that staff at risk for occupational exposure are immunized against hepatitis B.

To that end, this chapter focuses on:

- legal considerations,
- student immunization schedules,
- immunization compliance procedures,
- communicable disease control policies, and
- communicable disease control procedures.

Legal Considerations

Several important state regulations guide and govern communicable disease prevention and immunization in Wisconsin schools. Fortunately, state laws encompass a broad range of prevention practices and strategies, offering districts clear and well-defined roles and responsibilities. This structure helps school districts to develop solid policies to protect their students, staff, and ultimately the larger community by

- requiring specific immunizations,
- preventing the spread of illness,
- reporting some illnesses,
- temporarily excluding from school some children who are ill, and
- cooperating with state and local health agencies.

Relevant state statutes and administrative codes include:

- Wis. Stat. 252.04—Immunization Program and Wis. Admin. Code HSS 144–Immunization of Students
- Wis. Stat. 252—Definitions and Responsibilities and Wis. Admin. Code HSS 145–Communicable Disease
- Wis. Stat. 101.055, Wis. Admin. Code ILHR 32.50, and OSHA 29 CFR 1910.1030–Public Employee Safety and Health
- Wis. Stat. 118.25–Health Examinations
- Wis. Stat. 120.12(16)—School Immunization Plan
- Wis. Stat. 118.125–Pupil Records
- Wis. stats. 146.81-84–Patient Health Care Records

Wis. Admin. Code 144.03(10)—Release of Immunization Information

Immunization Program

Wisconsin first passed its immunization law—Wis. Stat. 252.04—in 1975 and amended it in 1980, 1982, 1988, 1990, 1992, 1995, and 1997. Wis. Admin. Code HSS 144 implements that law, which specifically addresses:

- definitions;
- minimum immunization requirements by age and grade level; and
- waivers for health, religious, or personal conviction reasons.

It also details the responsibilities of

- parents and adult students
- schools and day care centers
- local health departments
- the Wisconsin Department of Health and Family Services

Definitions and Responsibilities

The Wisconsin Department of Health and Family Services is responsible for protecting the public's health and welfare. Many of the responsibilities for surveillance, investigation, control, and prevention of communicable diseases are carried out by local health departments.

Wis. Stat. 252 outlines various departments' responsibilities related to communicable disease prevention and control, including:

- definitions,
- powers of the Department of Health and Family Services,
- duties of local health officers,
- reports of cases,
- sexually transmitted diseases,
- handling of foods,
- public protection in suspected cases of communicable disease,
- violation of laws relating to health, and
- the professional duties related to communicable disease in schools.

Wis. Stat. 252.21 ("Communicable Diseases, Schools, Duties of Teachers, Parents, Officers") requires that teachers, school nurses, or principals of schools and day care centers notify the local health officer if they know or suspect that a communicable disease is present in their facility. In addition, it permits any teacher, school nurse, or principal to send home a student suspected of having a communicable disease or any other disease specified by Department of Health and Family Services rules. Furthermore, it requires notification of the student's parent(s)/guardian(s) of the action and the reasons for the action.

Wis. Admin. Code HSS 145.06 further clarifies matters relating to preventing the spread of communicable diseases.

Public Employee Safety and Health

The intent of OSHA 29 CFR 1910.1030 is to minimize or eliminate occupational exposure to the Hepatitis B virus, human immunodeficiency virus (HIV), and other bloodborne pathogens. This regulation sets standards that private employers—including public and private schools and districts—must follow in developing a plan that will protect employees from reasonably anticipated exposure. Wis. Stat. 101.055 authorizes the state to adopt its own particular public employee health and safety standards. In addition, the Wisconsin Department of Workforce Development (formerly the Department of Industry, Labor and Human Relations or DILHR) did this by adopting Wis. Admin. Code ILHR 32.50(4), which applies OSHA standards for public employees.

Health Examinations

Wis. Stat. 118.25 requires school districts to establish physical examination and tuberculosis (TB) screening requirements on initial employment for all employees. The examination must include a TB skin test (mantoux) or a chest X-ray showing the employee to be free of TB in a communicable form.

School Immunization Plan and Compliance

Wis. Stat. 120.12(16)(a)(b) requires schools to develop and implement a plan to encourage compliance with state immunization laws and requires parents to present written evidence that their child has received specified vaccinations. In lieu of immunization, Wisconsin requires laboratory evidence of immunity to a specific disease known as a "serological titer." Parents may claim waivers based on personal conviction or religious beliefs, or a physician may sign a health waiver if the immunization is harmful to the health of the student.

Penalties for noncompliance with the law include possible exclusion from school for up to 10 days and a fine of not more than $25 per day if the district attorney chooses to prosecute. If the proper immunization or waiver evidence has not been presented, a school may issue notices for a student expulsion hearing on health and safety grounds (Wis. Stat. 252.04(5)(b)(4)). Like other nonexceptional-education-need expulsions, this would result from a failure to comply with a district's policies and/or procedures.

In addition, the State of Wisconsin requires school districts with less than 99 percent overall compliance in the previous school year to exclude all students in grades K-5 who are not in compliance with immunization laws.

Transfer of Immunization Information

While immunization information is considered confidential medical information, Wis. Stat. 146.82(2) declares that neither written nor verbal permission is required for the release of immunization information among those health-care providers defined in the statute, including local health departments, clinics, schools, and day care centers. Consistent with the statute, Wis. Admin. Code 144.03(10) permits the release of a student's immunization information, including the student's name, date of birth, and gender; the day, month, and year, and the name of the vaccine administered to a school or day care center without the written or verbal permission from a student or parent. Furthermore, Wis. Stat. 118.125 requires the transfer of pupil records, which includes immunization records, within five working days of receipt of any written request to do so.

Student Immunization Schedules

While some people might believe our technologically advanced society somehow ensures a fully immunized citizenry, scattered outbreaks of measles and pertussis in Wisconsin and throughout the nation have renewed an emphasis on the importance of immunization. They remind us that many children are not adequately protected and, therefore, are susceptible to communicable illnesses.

Ideally, by the time they are two years of age, children will complete the basic series of immunizations, including those against diphtheria, pertussis, tetanus, polio, measles, mumps, rubella, hemophilus influenza type B, and hepatitis B.

Unfortunately, no one agency currently monitors all children for compliance with immunization schedules. In fact, it is not until children enter a public school or day care that they come under the jurisdiction of state laws requiring immunizations.

While requirements vary from state to state, all states have immunization requirements for school attendance, usually based on recommendations of such national groups as the Center for Disease Control's Advisory Committee on Immunization Practices, the American Academy of Pediatrics, and/or the American Academy of Family Physicians.

Currently, only 67 percent of two-year-olds nationwide are adequately immunized against infectious diseases. In spite of that troubling statistic, many health-care professionals and educators believe that complete immunization for children is an achievable goal. To that end, in its publication *Healthier People in Wisconsin: A Public Health Agenda for the Year 2000*, the Wisconsin Department of Health and Family Services has set as its goal for the year 2000 a 90-percent immunization rate among two-year-olds.

Scheduling Guidelines

It is important to note that Wisconsin statutes outline *minimum* requirements, and that primary health-care providers may recommend other immunizations based on the health status of a particular child. Educators and parents should be aware of a number of benchmarks:

- State law requires parents to provide written evidence to the school of their child's vaccination against specific illnesses within 30 days of the child's admission to school.
- Students not fully immunized upon admittance to school must receive at least one dose of each age-appropriate vaccine within 30 days. (Note: Students entering from another school district in Wisconsin are not allowed this 30-day grace period because they were subject to the same immunization law in their previous school.)
- Children must receive the second dose of each vaccine within 90 days of admission. By the 30th day of the following year, students must have received their third (and fourth, if required) dose of diphtheria, pertussis, tetanus (DPT/DTaP/DT/Td), and polio and Hepatitis B vaccines.

Over the six school years between 1990-91 and 1995-96, requirements for a second dose of measles, mumps, and rubella (MMR) vaccine were gradually implemented. This change in the law was implemented after large numbers of both vaccinated and unvaccinated preschool children had recently developed measles due to inadequate vaccinations and vaccine failures. Beginning with the 1995-96 school year, students in all grades were required to have received at least two doses of MMR vaccine. (Figure 16 details current age and grade level requirements, along with cumulative minimum dosages.)

Beginning with the 1997-98 school year, Wisconsin's administrative rules requiring hepatitis B immunization for school-age children went

Figure 16

Immunization Requirements

	Type and Number of Required Immunizations				
Age/Grade	**DPT/DTaP/ DT/Td**	**Polio**	**MMR**	**Hepatitis B**	**Haemophilus influenza B***
5-11 months	2	2	0	2	2
12-23 months	3	2	1	3	3
2-4 years	4	3	1	3	3
K-12	4	4	2	3	

Note: Required immunizations upon entrance into kindergarten and seventh grade beginning in the 1997-98 school year, with a phase-in of other grades in subsequent years.

**Haemophilus influenza b (Hib) is required in day care centers only.*

Source: Department of Health and Family Services, Wisconsin Immunization Requirements: 1997-98 School Year, *Madison: WDHFS, 1997.*

into effect. That law requires all students, before entering kindergarten and grade seven, to receive hepatitis B immunizations for the five school years from 1997-98 through 2001-2002. The phase-in of this law will be completed in 2002, requiring kindergarten-only immunizations in the future.

The Advisory Committee on Immunization Practices makes exceptions in requirements for the fourth dose of DPT/DT/Td or polio vaccines. Similarly, Wis. Stat. 252.04 does not require that children who receive the third dose of either of these vaccines after their fourth birthday receive a fourth dose of the vaccine. (Note: The student's health-care provider may recommend a fourth dose.)

Immunization Compliance Procedures

As noted previously, the State of Wisconsin requires school districts with less than 99 percent overall compliance in the previous school year to exclude all K-5 students who are not in compliance with immunization laws.

To avoid the potential problems associated with such exclusions, school districts, working in cooperation with parents, local health departments, and local health-care providers/agencies, need to focus on acquiring and maintaining complete student immunization information. This may be particularly challenging in urban areas, where a high degree of mobility may mean that students were immunized at a variety of locations and that families have incomplete immunization information. School nurses can contact public health clinics and physicians' offices directly in attempts to track down immunization dates. (Again, state law does not require verbal or written permission for release of this confidential medical information if it is being shared in accordance with Wis. Stat. 146.82(2) among licensed health-care providers or Wis. Admin. Code 144.03(10) between schools, day care centers, and vaccine providers.)

If the school nurse successfully locates immunization dates, it is important to share that information with the child's parents.

The Wisconsin Department of Public Instruction recommends that school districts cooperate with local health departments in areas where large numbers of students are behind schedule for immunizations. Depending on the community, districts may function as a source of information and as an active coordinator of immunization clinics in a school and/or community setting. Districts and health departments may improve immunization rates by co-sponsoring such clinics, ideally at the beginning of the school year and again in the spring, and by promoting Immunization Awareness Month every April. Such efforts can be significantly enhanced by creating public awareness via local radio and TV stations, through which parents can be informed of the medical value of and legal requirements for immunization.

In addition, districts should provide to parents—either at kindergarten registration or upon transferring their child from an out-of-state school—printed information explaining Wisconsin immunization laws.

For their part, parents should compile, sign, and provide their child's school with a complete immunization history for each child. This should include the month, day, and year of each vaccination. The Wisconsin Division of Health's Immunization Program form, DOH 4020 (Figure 17), is available for this purpose. The school nurse or an individual who is knowledgeable about state laws and recommended immunization practices should review this history, which may contain erroneous or implausible dates easily corrected in consultation with parents.

Throughout the immunization audit process, the school nurse should provide parents with information about the immunizations that their child is lacking and the location where they can obtain needed immunizations. They should also encourage parents to discuss immunization needs with their family health-care provider. Since some families may not be able to afford a personal physician, school nurses should be familiar with alternative service providers, such as a local public health department, which provide basic immunizations at little or no cost.

Compliance Categories

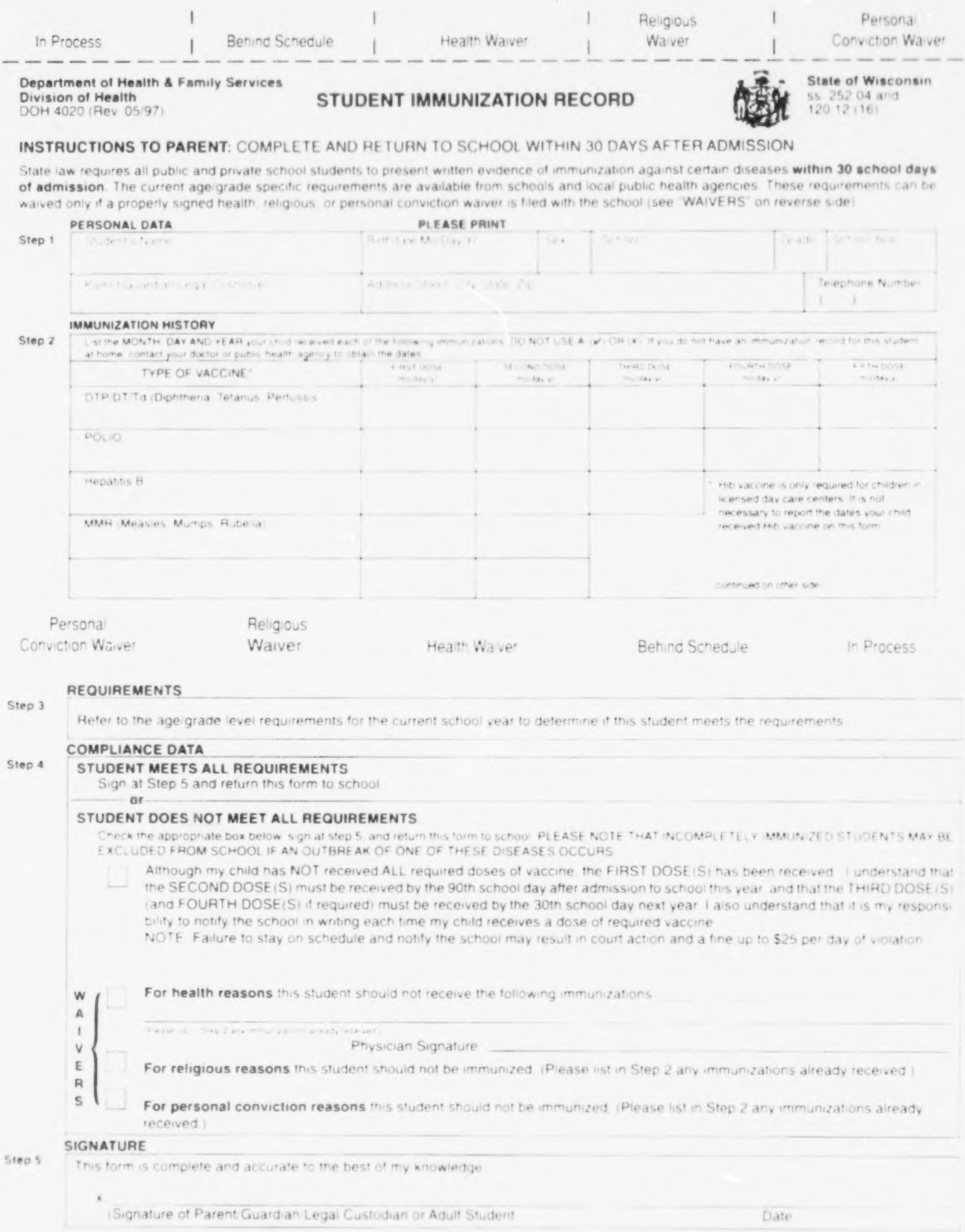
Upon reviewing parent-provided immunization information, the school will place each student in one of three compliance categories: compliant, noncompliant, and in-process.

Compliant

Compliant students have received the minimum number of doses of each vaccine required for their age or grade level. Parents may claim a waiver based on personal conviction or religious beliefs. In addition, a physician may sign a health waiver if the immunization is deemed harmful to the student's health. Though students with a waiver are complying with state law, they may be

Figure 17

Student Immunization Record



In Process | Behind Schedule | Health Waiver | Religious Waiver | Personal Conviction Waiver

Department of Health & Family Services
Division of Health
DOH 4020 (Rev. 05/97)

STUDENT IMMUNIZATION RECORD

State of Wisconsin
ss. 252.04 and
120.12 (16)

INSTRUCTIONS TO PARENT: COMPLETE AND RETURN TO SCHOOL WITHIN 30 DAYS AFTER ADMISSION

State law requires all public and private school students to present written evidence of immunization against certain diseases **within 30 school days of admission**. The current age/grade specific requirements are available from schools and local public health agencies. These requirements can be waived only if a properly signed health, religious, or personal conviction waiver is filed with the school (see "WAIVERS" on reverse side).

Step 1 **PERSONAL DATA** **PLEASE PRINT**

Student's Name	Birthdate Mo/Day/Yr	Sex	School	Grade	School Year
Parent/Guardian/Legal Custodian	Address Street, City, State, Zip				Telephone Number ( )

Step 2 **IMMUNIZATION HISTORY**

List the MONTH, DAY AND YEAR your child received each of the following immunizations. DO NOT USE A (✓) OR (x). If you do not have an immunization record for this student at home, contact your doctor or public health agency to obtain the dates.

TYPE OF VACCINE*	FIRST DOSE mo/day/yr	SECOND DOSE mo/day/yr	THIRD DOSE mo/day/yr	FOURTH DOSE mo/day/yr	FIFTH DOSE mo/day/yr
DTP/DT/Td (Diphtheria, Tetanus, Pertussis)					
POLIO					
Hepatitis B					
MMR (Measles, Mumps, Rubella)					

* Hib vaccine is only required for children in licensed day care centers. It is not necessary to report the dates your child received Hib vaccine on this form.

continued on other side

Personal Conviction Waiver | Religious Waiver | Health Waiver | Behind Schedule | In Process

Step 3 **REQUIREMENTS**

Refer to the age/grade level requirements for the current school year to determine if this student meets the requirements.

Step 4 **COMPLIANCE DATA**

STUDENT MEETS ALL REQUIREMENTS
Sign at Step 5 and return this form to school.

or

STUDENT DOES NOT MEET ALL REQUIREMENTS
Check the appropriate box below, sign at step 5, and return this form to school. PLEASE NOTE THAT INCOMPLETELY IMMUNIZED STUDENTS MAY BE EXCLUDED FROM SCHOOL IF AN OUTBREAK OF ONE OF THESE DISEASES OCCURS.

☐ Although my child has NOT received ALL required doses of vaccine, the FIRST DOSE(S) has been received. I understand that the SECOND DOSE(S) must be received by the 90th school day after admission to school this year, and that the THIRD DOSE(S) (and FOURTH DOSE(S) if required) must be received by the 30th school day next year. I also understand that it is my responsibility to notify the school in writing each time my child receives a dose of required vaccine.
NOTE: Failure to stay on schedule and notify the school may result in court action and a fine up to $25 per day of violation.

WAIVERS

☐ **For health reasons** this student should not receive the following immunizations: ______
(Please list in Step 2 any immunizations already received.)
Physician Signature ______

☐ **For religious reasons** this student should not be immunized. (Please list in Step 2 any immunizations already received.)

☐ **For personal conviction reasons** this student should not be immunized. (Please list in Step 2 any immunizations already received.)

Step 5 **SIGNATURE**

This form is complete and accurate to the best of my knowledge.

x ______
(Signature of Parent/Guardian/Legal Custodian or Adult Student) Date

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excluded from school if a disease outbreak occurs because they are not adequately immunized.

Noncompliant

Noncompliant students have not received the minimum number of doses of each vaccine required for their age or grade level. These students are either *behind schedule* or have *no record*.

In-process

In-process students have not received the minimum number of doses required for their age or grade level but are in the process of receiving vaccine doses in accordance with the scheduling guidelines outlined earlier in this chapter. The student becomes compliant upon receiving the third (or fourth, if required) scheduled dose. *Students can only be in-process during the kindergarten year, when they have enrolled after kindergarten from an out-of-state school, or during the phase-in of the hepatitis B requirement.*

Recordkeeping

Immunization information is part of each student's progress record (along with grades, courses taken, attendance, and extracurricular activities) as well as part of each student's physical health records. Other than directory data, progress records are the least-restricted type of student record. If the school district uses a computerized transcript, including immunization records with this transcript will facilitate the transfer of this information, especially when students move from one district to another.

The school nurse or a designated school staff member knowledgeable about Wisconsin immunization laws and practices enters immunization information into a student's permanent file in ink or into a computer database. The original immunization information form provided by the student's parents should also be filed in the student's record.

The State of Wisconsin requires year-round tracking and recording of student immunizations. This audit process currently consists of seven steps:

- On the 15th school day, the district sends a *notice letter* to parents of children who are not in compliance with the minimum requirements of state immunization laws.
- On the 25th school day, the district sends a *notice letter* to parents of children who are still not in compliance with state laws.
- After the 30th school day, districts with less than 99 percent overall compliance in the previous school year must exclude noncompliant students in elementary school for up to 10 days by issuing an *exclusion letter*. Exclusion is optional for noncompliant students in middle and high school grades.
- On the 40th school day, the district must complete and submit a "Student Immunization Assessment Report" to the local health department (LHD). This report details the number of students who meet minimum requirements and lists the names of students who are in-process, who are behind schedule, who have no record, and who have waivers.
- On the 60th school day, the school district completes a "District Attorney Report," which includes the names of and identifying information for students who are noncompliant (behind schedule or with no record).
- *Optional Step.* On the 80th school day, the district notifies parents of those children who are not in compliance with state law.
- On the 100th school day, the district submits a second District Attorney Report.

For ease of reference, Figure 18 ("Immunization Audit Schedule") may prove a useful tool for inservices and as a handout to parents.

In addition, the DHFS booklet *Wisconsin Immunization Requirements* includes information about this process as well as the forms and sample letters necessary to complete the process. DHFS mails this booklet annually to every school district. It is also available through a regional representative of the state immunization program.

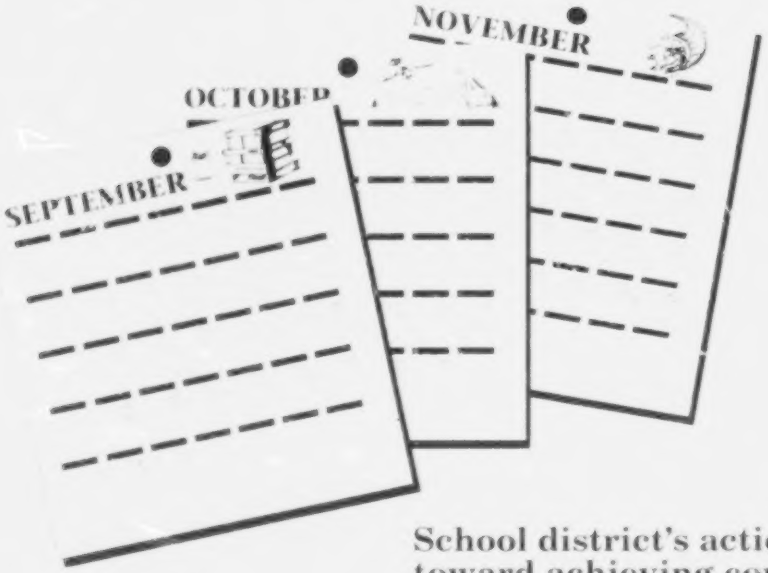
Electronic Recordkeeping

Auditing immunization records, mailing required letters to parents, and completing required reports are tasks which are often time-consuming and sometimes confusing. Changing enrollment and mobility in a district adds to the confusion.

To improve accuracy and decrease the time spent on the immunization audit, some districts have purchased or developed computer software to organize and track immunization data. This approach can reduce assessment errors when the computer program is used to determine compliance, streamline report production, identify students needing immunization, and generate letters and labels for required mailings to parents. How-

Figure 18

Immunization Audit Schedule



School year	School district's action toward achieving compliance
15th day	Notice letters are sent to parents of children with no immunization record or who are behind schedule.
25th day	Second notice letters are sent to parents of children with no immunization record or who are behind schedule.
30th day	Exclusion from school of K-5 students not in compliance with immunization laws in districts in which previous year's compliance was less than 99 percent. Exclusion is optional for additional grades or for districts with greater than 99 percent compliance.
40th day	The Student Immunization Assessment Report is sent to the local health department.
60th day	A report identifying noncompliant students is sent to the district attorney.
80th day	Second deadline notice letters are sent to parents notifying them that the student is not in compliance with state law.
100th day	A report identifying noncompliant students who missed the second deadline is sent to the district attorney.

ever, as with any database, the lists and reports are only as accurate as the person who programs and enters the data. For this reason, it is essential to have the school nurse involved from the outset in any discussion about creating and maintaining an immunization database which will require frequent updates and quality control checks.

Interest has been growing in developing computer databases that would serve more than one agency, such as a centralized, countywide database available to health-care providers, health departments, and schools. Such a database could hold records from different agencies so that each could get a complete picture of a child's immunization record. It would prevent over-immunization of children, while sharing information with health-care providers that would help measure progress in increasing immunization rates. Milwaukee County plans to implement its electronic database, the Milwaukee Immunization Registry System (MIRS), this year. Currently, a statewide effort to implement an electronic database is underway, with full implementation planned by the end of the 1999 calendar year.

Communicable Disease Control Policies

The suspicion or presence of a communicable disease can often cause strong parental and teacher reaction, especially if it is believed, whether correctly or incorrectly, that one or one's child is at risk of contracting the illness.

In many cases, the intensity of the reaction is inconsistent with the severity of the illness or the degree of threat it poses in the school setting. Concerned responses can be greatly reduced by proactive and, where necessary, the timely and responsive education of parents, students, and school staff members. As the person with the knowledge to provide such clinical information as well as the training to interpret and apply it to specific circumstances, the school nurse is the logical person to spearhead any such health education effort in the school setting. Using resources from a variety of providers, the nurse can provide all concerned parties with accurate, up-to-date information about diseases, the ways in which they are spread, ways people can reduce the likelihood of infecting themselves or others, and actions to take should exposure occur.

It is important for local health departments to be involved in communicable disease policy development. School nurses play an active role in assisting staff members and parents to understand district policies addressing the reporting of suspected or actual cases of communicable diseases in students and staff workers. The Wisconsin Division of Health groups reportable communicable diseases in four categories.

- *Category I* diseases are of urgent public health importance and must be reported to the local health department immediately by phone when a case is suspected/identified. (See Figure 19 for a list of reportable Category I, II, and III communicable diseases.)
- *Category II* and *Category III* diseases are considered less urgent and must be reported within 72 hours of being suspected/identified.
- *Category IV* diseases must be reported within a month of being suspected/identified.

School districts must identify the district staff member responsible for reporting cases of communicable illness, including chicken pox.

Local school district policies should address the preventive measures necessary to protect the health of all students and staff, the procedures for the immediate care of students or staff who develop a potentially communicable illness, and the special needs of children with chronic infectious illnesses that are noncontagious under normal conditions. In support of IDEA-R97, Section 504, and the Americans with Disabilities Act, federal and state courts have held that children with chronic infectious diseases are entitled to a free and appropriate public education in the least restrictive environment.

Special consideration is given to students or staff members with suppressed immune systems who may have a higher-than-normal risk of severe complications or morbidity from common communicable illnesses. It is both the role and responsibility of the school nurse to make every effort to identify these students and staff and to constantly monitor the school environment for threats to their health. Working within the context of a health advisory team, the school nurse may temporarily remove these students and staff members from school to protect them during an outbreak of a contagious disease.

Exposure to Bloodborne Pathogens

The regulations of the Occupational Safety and Health Administration (OSHA) of the U.S. Department of Labor and the Wisconsin Department of

Figure 19

Reportable Communicable Diseases

Category I

The following diseases are of urgent public health importance. Report IMMEDIATELY by telephone to your patient's local health officer upon identification of a case or suspected case. Complete and mail an Acute and Communicable Diseases Case Report (DOH 4151) within 24 hours.

- Anthrax
- Botulism
- Botulism-infant
- Cholera
- Diphtheria
- Food or water borne out-breaks
- Hepatitis Viral Type A
- Measles
- Pertussis
- Plague
- Poliomyelitis
- Rabies (human)
- Rubella
- Rubella (congenital syndrome)
- Tuberculosis
- Yellow Fever

Category II

The following diseases must be reported to the local health officer on an Acute and Communicable Diseases Case Report or by telephone within 72 hours of the identification of a case or suspected case.

- Acquired Immune Deficiency (AIDS)
- Amebiasis
- Blastomycosis
- Brucellosis
- Campylobacter enteritis
- Encephalitis, viral (specify etiology)
- Giardiasis
- Hepatitis, viral
  - Types B, non-A, non-B (Type A is in Category 1)
- Histoplasmosis
- Kawasaki Syndrome
- Legionnaires disease
- Leprosy
- Leptospirosis
- Lyme disease
- Malaria
- Meningitis aseptic (specify etiology)
- Meningitis bacterial (specify etiology)
- Meningococcal disease
- Mumps
- Nontuberculous mycobacterial disease (specify etiology)
- Psittacosis
- Q fever
- Reye Syndrome
- Rheumatic fever (newly diagnosed)
- Rocky Mountain Spotted Fever
- Salmonellosis
- Sexually transmitted diseases
  - Chancroid
  - Chlamydia trachomatis
  - Genial herpes infection
    - Primary (1st clinical infection only)
  - Gonorrhea
  - Granuloma inguinale
  - Lymphogranuloma venereum
  - Nongonococcal cervictis
  - Nongonococcal urethritis
  - Sexually transmitted pelvic inflamatory disease
- Shigellosis
- Tetanus
- Toxic-shock syndrome
- Toxic substance related diseases
  - infant methemoglobinemia
  - Lead intoxication
    - (specify Pb levels)
      - Other metal poisonings
- Other organic chemicals poisonings
  - Pesiticide poisoning
- Toxoplasmosis
- Trichinosis
- Tularemia
- Typhoid Fever
- Typhus Fever
- Yersiniosis

ALSO: Suspected outbreaks of other acute or occupationally-related diseases should be reported.

Category III

Human immunodeficiency virus (HIV) infection report written 72 hours to state epidemiologist.

Category IV

Report the total number of Chicken pox cases each week Saturday through Friday.

Wis. Stat. 252 and Wis. Admin. Code HSS 145 Require Reporting of Communicable Diseases

Persons reporting include any person licensed under Ch. 441 and 448, Stats., or any other persons having knowledge that a person has a communicable diseases, such as:

a. a person in charge of infection control at a health care institution
b. school nurses, principals of schools, and day care center directors
c. laboratory directors

NOTE: Pending legislative approval, voluntary reporting of the following communicable diseases is requested: Cryphosporidium, E. coli 0157 H7, Hemolytic Uremic Syndrome and Ehrichiosis.

Source: DOH 4151 Acute and Communicable Diseases Case Report (Rev. 11/89)

Workforce Development (formerly the Department of Industry, Labor and Human Relations) relating to preventing occupational exposure to bloodborne pathogens require development and implementation of *The Model Bloodborne Pathogen Exposure Control Plan*, which is available from the Wisconsin Department of Public Instruction and can be adapted by districts to meet their needs.

The Model Bloodborne Pathogen Exposure Control Plan includes detailed instructions on

- methods for implementing universal precautions,
- engineering/and work place controls,
- personal protective equipment, and
- hepatitis B vaccination.

Three important points must be considered when developing policies and a plan to comply with the bloodborne pathogen standard:

- It applies to employees.
- Not all sections of the standard are applicable to the school setting.
- Staff members who are eligible for no-cost hepatitis B vaccinations must receive information regarding its safety, efficacy, method of administration, and benefits. The vaccine must be offered free of charge after the training and within 10 working days of initial assignment. Employees declining the vaccination must complete a written declination statement. At any time, staff members who initially decline the vaccination may request to receive it at the district's expense. The district may choose to contract this service with a local public health department, purchase the vaccine for administration by the school nurse, or refer the staff member to their physician for a vaccination which will be paid for by the district. If the district provides the vaccination, it must keep a record of vaccination, including the date administered, specific vaccine, manufacturer, lot number, dosage, and site of administration.

The exposure-control plan that the school district adopts should be available to all district staff members at their work site and in a form that they can read. Staff members should know the time frame for reporting an occupational exposure to blood or other potentially infectious material as well as the name of the person to consult in the event of such an exposure. According to state statutes and the model standards, schools are required to

- establish a written exposure control plan and identify workers at risk of occupational exposure.
- develop written procedures for cleaning, for handling contaminated materials, and for disposing of hazardous waste within all district buildings and facilities.
- provide (1) training sessions for staff members whose job assignment includes providing first aid or potential exposure to blood and (2) the equipment (including readily accessible personal protective equipment), materials, and facilities necessary to provide such care. Such staff members may include those who work as teachers or teaching assistants for children with disabilities; who work with teen parents or their infants; or who participate in particular laboratory-based instruction, including biology, chemistry, and family/consumer education training.
- provide all staff members with an annual training session and additional updates when procedure modifications are necessary and affect staff members' occupational exposure.
- provide free hepatitis B vaccinations to employees whose designated job assignment includes rendering first aid or occupational exposure to blood or other potentially infectious material.
- provide medical follow-up and counseling for employees after a work-site exposure.
- maintain confidential records of training, vaccination, and exposure for 30 years.

Risk and Environment

School administrators and staff members must consider the environment of the school when determining the level of risk a communicable disease poses. Such considerations should, of course, be taken into account when developing related policies.

To assist them in the development of policy and the handling of suspected or actual incidents in the school, districts should acquire and use one of the widely accepted references on communicable disease. The current edition of the *Red Book: Report of the Committee on Infectious Diseases*, published by the American Academy of Pediatrics, and *Benenson's Control of Communicable Diseases in Man*, published by the American Public Health Association, provide alphabetical listings and information on all communicable diseases which districts can use in making decisions about particular cases. In addition, the Wisconsin Department of Health and Family Services has compiled communicable disease information sheets and a "Communicable Disease Chart," which cite applicable state statutes and list a variety of diseases, their incubation periods, period of communicability, modes of transmission, signs and symptoms, and common control measures/public health responses.

In the event of a suspected or actual case of a communicable disease in a student or staff member, the school nurse or an administrator should determine, in conjunction with a physician or the district's medical advisor, based on medical findings, whether such a risk, in fact, exists. Upon confirmation of actual risk, the application of related policies should apply equally to students and staff members.

Common Communicable Diseases

School districts may want to develop written guidelines or protocols for specific communicable diseases and conditions that are frequent, such as:

- head lice
- strep throat
- impetigo
- conjunctivitis
- ringworm
- chicken pox
- erythema infectiosum (Fifth Disease)

Districts are well advised to address other communicable diseases, including hepatitis and HIV, which cause a high degree of staff and parent concern.

The procedures should address exclusion of students and staff, both on the basis of their own illness and/or their exposure to the illness of another student or staff member. The procedures should specify the individual in each school who has the authority to exclude students or staff due to communicable disease.

Given the potentially disruptive and frightening effect such decisions may have on children and parents, districts may find it helpful to create and reproduce information sheets to give to parents about the illnesses. They may also develop sample or model letters to parents regarding the presence of specific illnesses in their child's classroom and the procedures that will be followed in addressing specific situations. (See Appendix I for sample letters reporting head lice or conjunctivitis.)

TB Screening of Staff

Wis. Stat. 118.25 provides for the exclusion of staff members who have tuberculosis (TB) in a communicable form. The law gives school boards the authority to determine the requirements for physical examinations and TB screening and for physical examination intervals beyond the time of the initiation of employment for all employees. The examination must include a TB skin test (Mantoux) or a chest X-ray showing the employee to be free of TB in a communicable form.

With the increase of TB in certain populations in Wisconsin, districts are advised to consult their local public health department, school nurse, and medical advisor to establish appropriate ongoing physical examinations and TB screening requirements for staff members.

Communicable Disease Control Procedures

Wisconsin state law requires implementation of a broad range of prevention practices and strategies, from simple measures of good hygiene to specific procedures that protect staff and students from life-threatening diseases. Yet, for all that such laws offer in issuing requirements and providing outlines, it takes the school district to place knowledgeable people in policy-making roles, to invest in the necessary informational resources, and to become familiar with the related legislation to create the most effective policy and procedures for dealing with the spread of communicable diseases.

The universal precautions that school nurses model in daily practice and teach in a health education class or inservice form the foundation of state legislation to halt infection. Those precautions are also contained, in part, in the DPI bulletin *Model Bloodborne Pathogens Exposure Plan for Wisconsin Public Schools*, which is significantly shaped by OSHA regulations.

Together, universal precautions and an effective exposure response plan help keep schools safer for students and staff members alike.

Universal precautions refers to the consistent, universal use of necessary precautions to prevent the spread of infections when coming into contact with another person's germs. Universal precautions are intended to prevent transmission of infections as well as to decrease the risk of exposure for care providers and students. These measures require the use of appropriate barriers to prevent skin and mucous membrane exposure when contact with blood or body fluids of others is anticipated. Because it is currently not possible to identify all infected individuals, school staff members must use these precautions with every student regardless of their medical diagnosis.

Since it is understood that students and staff members can prevent or decrease the spread of infectious diseases with the use of basic principles of good personal hygiene, *The Model Bloodborne Pathogens Exposure Plan* advises school districts to develop exposure control plans and provides them with detailed instructions and considerations.

Staff members with job descriptions that require them to provide first aid as a duty—including playground supervisors, coaches and athletic trainers, health office assistants, secretaries, and nurses—should receive specific inservice training on universal precautions relating to injuries and illnesses and be provided with such supplies as disposable gloves to use in responding to such circumstances.

In addition, districts should include instruction for students, beginning in the early elementary grades, on universal precautions and the importance of hand washing. Among the important skills they should be taught are handwashing and how to avoid contact with body fluids from another person when providing that person with assistance.

Hand Washing

Hand washing is perhaps the simplest and single most important step any person can take to protect themselves and others from infectious disease. Yet, perhaps because of that simplicity, the value of hand washing is often underestimated when considering infection control.

To remove germs and prevent transmission, students and staff workers should wash their hands

- for a minimum of 15 seconds using a combination of warm water, soap, and aggressive scrubbing, especially after caring for one's personal needs or those of students (including feeding, diapering, and/or grooming)
- before preparing food for others, after sneezing, after blowing one's nose, and after rubbing one's eyes.

School nurses and teachers should emphasize through classroom teaching and demonstration the importance of hand washing to students starting in primary grades. Soap, warm water, and paper towels should be readily available to all students and staff so that they can wash hands as needed. Liquid soaps are preferable, as they are less likely to be contaminated by handling.

Athletics

Due to the physical nature of athletics as well as the interpersonal physical contact associated with nearly every sport, the risk for transmission of communicable diseases in such settings increases.

Virtually every sport—whether a contact sport, like football, or a noncontact sport, like tennis—offers opportunities for injury and bleeding. Any time blood is present in such events, officials must halt play and observe universal precautions in caring for the injured athlete. Trained staff or students must clean the playing area and equipment with a disinfectant that deactivates germs and viruses, including HIV. Student athletes must have their cuts or scrapes properly cleaned and bandaged before returning to competition, if such a return is indeed appropriate.

Because of the close skin-to-skin contact between participants and the use of mats that can easily become contaminated with body fluids, wrestling poses a potentially higher risk for which students and staff members should be properly prepared.

Head Lice

Few conditions cause such widespread concern and anxiety as head lice (*pediculosis capitis*) infestations. While lice are parasites that live on human blood, they are not known to be carriers of other diseases. Appropriate treatment of the hair and cleaning of the environment can eradicate them.

It is important for school districts to have a plan to identify and respond to head lice cases. The district should screen the classmates of identified students in the elementary grades. In later years, screening may only be necessary for locker mates or close friends. The district should provide those students or staff members who may have been exposed to head lice from another person written instructions explaining the communicable nature of head lice and how to care for themselves to prevent infestation.

The district should also screen siblings in the same district. When siblings attend other schools or day care centers, districts should contact those facilities. The district should discretely exclude the identified student from school and provide parents with information on how to care for a child with head lice and how to assess and address potential infestation in the home. Parents should be

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informed that treatment of the hair should include combing the "nits" (lice eggs, which attach firmly to the hair) out with a fine tooth comb, since the shampoo or rinse does not kill all eggs. The school nurse, often working with other student services providers, should also determine whether families

- may need additional resources or information;
- can afford needed medication;
- need training on such topics as clean-up, prevention, control, and treatment; and/or
- need more specific assistance in acquiring such resources/training.

The custodian should be notified of the need for clean-up measures in the classroom, which may include vacuuming rugs and removing such contaminated items as, in the case of younger students, stuffed animals.

School districts must also set policies regarding return to school. While some districts require only treatment with an appropriate pediculicide, others enforce a "no-nits" policy due to the emerging resistance of head lice to pediculicides.

Finally, schools should consider follow-up screening in classrooms to ensure that new infestations are not occurring. The Wisconsin Division of Health's *Public Health Guide for the Prevention, Control, and Treatment of Head Lice Infestations in Schools* provides recommendations for the prevention and control of head lice in schools. The Wisconsin Association of School Boards provides an outline of considerations when reviewing or revising policies and procedures addressing head lice in schools.

Exclusion

In making decisions about excluding a child from school, the district should weigh the ease of communicability of a specific illness or condition in the school setting with the risk it poses to students or staff. For example, while colds are easily transmittable, especially in the early stages, most pose little health risk to students and staff. Thus, students or staff with colds need not be excluded, unless they feel unable to participate in their normal school activities.

However, measles, which is also easily transmittable in the school setting, poses a high degree of risk to students and staff, including possible serious long-term health problems. Consequently, the district should immediately exclude from school students or staff with measles or who are suspected of having measles. The school district should also take immediate measures to prevent the spread of measles.

The district should not exclude students from school when the risk of transmission in the school setting is nonexistent or when the district can control the risk of transmission through education of students and staff members and/or through the use of supplies to implement hygiene measures.

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Medication Administration

5

Introduction

While infectious diseases were once the leading cause of morbidity and death in children, today chronic illnesses and conditions (for example, allergies, asthma, diabetes, HIV, neuromuscular and seizure disorders), including those related to student behaviors (such as attention deficit disorder and other mental health conditions), have a much larger impact on students and the school setting.

Over the past decade, the number of students requiring the administration of medication (any prescription or nonprescription drug used to prevent, diagnose, cure, or relieve signs and symptoms of disease or injury) and health procedures during the school day has sharply increased. A school nurse who may have once attended to administration of single doses to a handful of students must now address numerous chronic medical conditions and complex health conditions. This increase is directly related to major trends, such as those described in the opening chapter of this publication, which have significantly changed the public school's responsibility for student health.

In addition, due to increased demands on families to earn two incomes and on single parents to earn a crucial primary income, children often return to school sooner—sometimes too soon—following acute illness.

Furthermore, children who are medically fragile—those who are often said to have "special health-care needs"—are attending public schools in greater numbers, sometimes requiring significant supportive care throughout the school day.

Finally, an increasing number of children live in families that lack access to and connections with any or adequate health care; this increases the burden on schools to intervene and assist parents in securing needed care for their children.

By state and federal law, the administration of medication and school health services during the school day is a basic service that all districts must make available. Policies, procedures, and trained personnel need to be in place to provide related routine and emergency medical care. The challenge is to do so safely, legally, and efficiently.

To be most successful in meeting the demands of each of those areas of concern, nurses will need to

- know and understand the Wisconsin Nurse Practice Act as it relates to medication administration, delegation, and supervision;
- know and understand Wisconsin statutes permitting school district administrators to designate the administration of oral medication to nonprofessional school health staff;
- know and understand their district's medication policies and procedures, and work with school district staff to review and revise them as needed;
- know and understand medications frequently used by school-age children; and
- implement systems for documenting medication administration, for reporting medication errors, and for supervising and monitoring nonprofessional school health staff who may be delegated the task of administering medications.

To assist readers in achieving those competencies, this chapter will address:

- legal considerations,
- administrative procedures,

- medication administration and documentation, and
- special orders.

Legal Considerations

Complex questions have arisen regarding the administration of both prescription and over-the-counter (OTC) medications. Three main regulations and their corresponding administrative codes govern medication administration in Wisconsin schools:

- Wis. Stat. 118.29–Administration of Drugs to Pupils and Emergency Care
- Wis. Stat. 121.02(1)(g) and Wis. Admin. Code PI 8.01(g)–Emergency Nursing Services
- Wis. Stat. 441–Wisconsin Nurse Practice Act and Wis. Admin. Code N6 and N7

Each is meant to help school districts

- encourage attendance by students requiring medication administration during the school day and school-sponsored activities,
- set uniform minimum standards for safe and proper administration of medications, and
- recognize the school nurse's professional role in managing medication administration in the school district.

Administering Drugs to Pupils

In 1983, responding to concerns raised by parents and professionals about medication administration in schools, the Wisconsin legislature enacted Wis. Stat. 118.29, which governs the administration of prescription and nonprescription medications in the school setting. The statute provides minimum standards for the safe and proper administration of medications in all public and private elementary and secondary schools to ensure that students requiring medication during the school day will be able to attend school. The administration of medications—which is a part of the daily practice of medicine, nursing, and other health-care professions—is governed by the Wisconsin Department of Regulation and Licensing.

With the exception of the administration of oral medications (as described in Wis. Stat. 118.29), licensed health-care professionals are responsible for making decisions about health-care tasks, including medication administration, which may safely and legally be delegated to others and their responsibilities in delegating such tasks. In so doing, they are well advised to work closely with other health-care professionals, parents, and school personnel. Together, they may decide that, depending upon the circumstances, food service workers and bus drivers can, with appropriate training and written authorization, play a part in administering medications which may be necessary for a student to take during school time or while involved in school activities. Designated personnel may administer to a student

- any drug which is to be taken orally that is sold lawfully over the counter without a prescription, in compliance with the written instructions and consent of the student's parents or guardians; and
- a prescription drug which is to be taken orally, in compliance with the written instructions of a physician or advanced practice nurse prescriber and the written consent of the student's parents or guardians.

Furthermore, the law notes that

- any person administering such medications in accordance with state law is immune from civil liability for those acts or omissions, unless the act of omission constituted a high degree of negligence; and
- any district administrator or school principal who authorizes another person to administer a drug in accordance with the law is also immune from civil liability for the act of authorization, unless the act of authorization constituted a high degree of negligence.

It is important to note that this law *does not apply* to health-care professionals. Furthermore, the law does not require a school nurse to authorize the administration of oral medication, although it does recommend that the district seek the assistance of a registered nurse and a physician, both of whom are licensed to practice in Wisconsin and are in good professional standing, in developing a written district policy. The school board must adopt a written policy that includes procedures for

- obtaining and filing in the school the written instructions and consent required from both the parent and the physician,
- periodic review of such written instructions,
- storage of prescription and nonprescription drugs,
- appropriate instructions and training for persons who may be authorized to administer prescription or nonprescription drugs to students, and
- recordkeeping.

To nonprofessional school health personnel, the fourth step is particularly valuable, as it offers essential instruction on medication administration.

While school districts may require any of its employees to administer *oral* medications, only health-care professionals can be required to administer medication by other means. Because districts are regularly asked to administer medications by means other than orally—including topically; insertion into the eye, ear, and/or nose; inhalation; injection; and rectally—districts need to be prepared to respond to such requests. Providing these types of health-care services is part of the regular practice of nursing and other health-care professions and, as such, is governed by the Wisconsin Department of Regulation and Licensing.

Nurse Practice Act

Under Wisconsin's Nurse Practice Act (Wis. Stat. 441.11(4)), registered nurses have the authority to perform "general nursing procedures and techniques which acts are considered the independent practice of nursing."

Medication administration is recognized as a fundamental nursing procedure. Among the more complicated procedures or techniques administered by nurses are urinary catheterizations, nebulizer treatments, and gastrostomy feedings. Registered nurses may provide, with a physician's order, each of these services independently or may delegate the task to a licensed practical nurse or to individuals in the school who are not licensed to provide health care, including teachers, principals, secretaries, teacher aides, and volunteers.

While delegating responsibility for providing such services may seem unusual, it is a viable option covered by both Wis. Stat. 441 and Wis. Admin. Code N6.03(3), which state that a nurse may delegate to unlicensed persons the provision of those services if appropriate supervisory requirements are met. These would include initial evaluation by the nurse of the extent to which the nursing act may be delegated and such delegation appropriately accepted by the unlicensed school employee. Considerations in this regard would include the general education, intellectual and emotional qualifications of the delegate, willingness of the delegate to undertake the delegated act, the opportunity to adequately train the prospective delegate, and determination that the prospective delegate will perform the delegated act with sufficient frequency to ensure continuing competency in its performance.

Only *nursing* acts can be delegated to licensed practical nurses and nonprofessional school health personnel and only by registered nurses. The delegation of *medical* acts—such as the insertion or replacement of tracheostomy or gastrostomy tubes—in the school setting requires training of the licensed or unlicensed employee/volunteer by a physician, who also conducts ongoing supervision to ensure that they perform the medical act correctly and safely. When a physician delegates a medical act to a registered nurse, the nurse is performing the act under the general supervision of the physician and cannot delegate that medical act. Districts wishing to determine whether an act is a nursing or medical act may consult with the state boards for medicine and nursing.

The relationship of Wis. Stat. 118.29 to Wis. Stat. 441 becomes apparent when school districts are asked to administer medications by means other than oral ingestion. For example, a school administrator may suggest assigning a person to assist with nursing care; however, state law limits such assignment decisions to nurses (in the case of nursing acts) and physicians (in the case of medical acts), who may select and assign such tasks to licensed practical nurses or nonprofessional school health personnel. It is important to note that nursing and medical acts appropriately assigned to a person may not, by that person, be further delegated to another person.

Nonprofessional school health personnel—such as a principal, teacher, or school secretary—who perform nursing or medical procedures (with the exception of administering oral medications and basic first aid) without delegated authority from a registered nurse or licensed physician may be found to be illegally engaging in the unlicensed practice of nursing or medicine. Under Wis. stats. 441 and 448, such persons could be subject to criminal penalties or injunctive action and may lose immunity from any civil suit which may result from any such illegal provision of health-care services. However, such a person, if a school employee, may be shielded from personal loss in accordance with Wis. Stat. 895.48 *if* it is found that they acted within the scope of their employment in providing such care.

Emergency Nursing Services

Wis. Stat. 121.02(1)(g) and Wis. Admin. Code PI 8.01(g), commonly referred to as Standard (g), requires each district to provide emergency nursing services. It includes the administration of medication at school-sponsored activities, including (though not limited to) curricular, co-curricular, and extracurricular activities (such as field trips; athletic, drama, and music events; and dances). Standard (g) also requires a district to develop with the assistance of a registered nurse and medical advisor, a written policy governing the administration of medications to students and include a method by which it will record all medications administered by school personnel.

APN Prescriptive Authority

In January 1995, the Wisconsin Board of Nursing adopted Wis. Admin. Code N8 granting prescriptive authority to nationally certified Advanced Practice Nurses (APN) upon fulfillment of specific educational and continuing education requirements related to the study of pharmacology and pharmacotherapeutics *and* successful completion of a jurisprudence examination. Authorization to prescribe and administer medications within their area of expertise garners such APNs the title of Advanced Practice Nurse Prescriber (APNP). The APNP must use that credential when signing prescriptions. In addition, as of July 1, 1998, APNPs must hold a master's degree.

Administrative Procedures

While the school nurse—whose professional training includes pharmacology, medication administration, nursing procedures, and legal issues—should regularly provide leadership in developing policies and procedures, districts will benefit from the involvement of others, including school personnel, the medical and public-health community, and parents. Such partnerships help engender a better, more widespread understanding of all procedures, including those relating to administration of medications.

In conjunction with each participant, the nurse should develop policies and procedures which take into account the practical realities of daily life in the school setting.

It may surprise some to learn that, in Wisconsin, nonprofessional school health personnel most often administer medications. In fact, the 1990 *Study of Specialized Physical Health Care Services in Wisconsin Public Schools* survey noted that school secretaries lead the way in the administration of medications, followed by special-education teachers and then school nurses. This affirms the need both for broad participation in any medicine-administration program and nurses' understanding of the need for such cooperation by non-nursing professionals.

The district should write its medication administration policies in a format consistent with other district policies. The policy should address the overall goal and outline the steps staff members and volunteers are expected to take to achieve that goal. Policies should allow discretionary action by the administration when appropriate but be specific enough to provide clear guidance to those responsible for medication-administration tasks.

Communicating those policies, procedures, and goals to students, staff members, parents, and other community health-care professionals is essential. The district should use a variety of media, including the school newspaper or newsletter, the community newspaper, and local radio and cable television stations, to routinely notify all interested residents about school health programs. The information provided may include:

- a detailed explanation or meaningful overview of the policies and procedures related to medication administration;
- the rights and responsibilities of students who require the administration of medication during the school day and during school-sponsored activities; and
- a recommendation to parents and health-care professionals to consider medication administration plans which, if at all possible, avoid or minimize school-day doses, so as to limit the amount of disruption to the student's day.

Consent

Depending on each student's circumstances, medications will be needed either on a short-term or continuing basis. In addition, the actual administration during that period may vary, from routinely scheduled doses (to treat infections, for example) to as-needed doses (such as ones to treat occasional migraine headaches). As-needed doses are often referred to as PRN (*pro re nata*, meaning "as circumstances require") doses. Whether a student requires medication on a routine or PRN basis, the guidelines for consent remain the same.

Parental Consent

Both prescription and nonprescription medications may be given only with a parent's/guardian's written consent, which should be given to the district on a consent form designed by the district (see Appendix J, "Parent/Guardian Medication or Procedure Consent Form"). Policy and consent forms should be readily available in school manuals, parents' handbooks, school offices and on the district's website as internet access becomes more available. It may prove helpful to print the district's medication administration policy on the back of the consent form to educate parents and avoid misunderstandings. In addition, printing the form in a distinctive color may help parents more readily distinguish it from the numerous other papers and forms they receive from the school throughout the year.

The form should include the

- student's name, address, and phone number
- name of the drug
- reason for the medication
- dose the student should take
- frequency/time of administration
- mode (method) of administration
- possible reactions the student may experience
- parent's signature
- date the form was signed

Districts may find it helpful to refer to the consent form (see Appendix J) used by the Madison Metropolitan School District as a guide in developing their own form.

Physician/Other Provider Authorizations

Prescription medications should be given/taken only with written instructions of a physician or other health-care provider legally authorized to prescribe medications. State law requires school districts to obtain written consent from parents before taking on the task of administering such medications to students in the school setting. Consequently, districts must decide whether they will also require a physician's written instructions and/or authorization for nonprescription medications. If the district chooses to require authorization for the administration of both prescription and nonprescription medications, the form should include the

- student's name, address, and phone number
- name of the drug
- reason for the medication
- dose the student should take
- frequency/time of administration
- mode (method) of administration
- name, address, and phone number of the prescribing physician
- acknowledgement that the physician will accept personal communication from the person who will be administering the medication
- start and end date for administration
- possible reactions the student may experience
- appropriate responses of school personnel to and documentation of any reactions
- date the form was signed

Appendix K ("Sample Medication Administration Authorization Form") offers districts a template on which they can base their own district-specific parent and physician authorization forms. In an effort to promote the widespread and consistent use of such forms, districts may wish to distribute an appropriate quantity of blank forms directly to local clinics, physicians, and hospitals for completion upon writing a prescription for a student.

Delivery of Medications to School

School districts should plan for the transportation of medications to the school office or health office and the notification of parents about reordering. In some cases, the school can depend on students to tell parents that their supply is getting low. In other situations, a phone call or note may be needed.

For children on routine daily medication, it is advisable for the school and the parents to work out details regarding notification for refills at the beginning of the school year. The safest and most secure method of transportation is for parents to deliver refills to the school health office, where it is received by the school nurse or a properly trained school staff member whose work is regularly monitored by the school nurse. This approach prevents loss of medications and provides for the personal safety of all students.

Districts should know that, due to the tight controls placed on some medications, particularly those classified as controlled substances, families may find it difficult, if not impossible to quickly replace Schedule 2 prescriptions lost on the way to school.

Medication-Specific Procedures

A number of other procedures are critical to the administration of medications to students.

Appropriate Labeling and Containers

Drugs should be sent in a pharmacy-labeled container with the

- student's name
- name of the drug

- dose the student should take
- frequency/time of administration
- mode (method) of administration
- directions
- date of expiration

When asked, pharmacies will provide additional labeled containers for children who take the same medication at home and at school. It is advisable for over-the-counter (nonprescription) drugs to have the manufacturer's label identifying the medication, its ingredients, dosing recommendations, possible drug interactions and/or warnings in addition to the student's name printed on the container.

Counting/Checking-in Medications

School districts should consider whether medications need to be counted on arrival at school in order to verify the number of pills received. If pills require counting on arrival—particularly advisable with Schedule 2 controlled substances—a staff member should document the count on the medication administration log.

In addition, schools should develop a procedure for disposing of medications that parents do not reclaim by the end of the year. This may include notifying parents prior to the end of the year that medications should be picked up by a certain date or they will be discarded. It would be prudent for districts to develop medication-disposal procedures, which should include documenting the act of disposal by the nurse.

Storage of Medication at School

Whether or not a medication requires refrigeration, it should be stored in a securely locked, clean container or cabinet accessible to the person(s) administering it but not to unauthorized persons. In circumstances in which students are authorized to self-administer their medications, arrangements must include a safe and secure place to store the medication.

Medication Schedules

School districts should consider the best way to handle multiple doses of medication during the school day if the student arrives at school late. It is critical to decide whether to adjust the schedule or to skip the missed dose. Since these situations are quite common, it must be clear to the person responsible for medication administration which decisions they can make independently and which require consultation with the person responsible for delegation or designation. Regardless of the modification, the nurse should contact the student's parent(s)/guardian(s) and may need to contact the child's local health-care provider.

Dispensing Medication

No one should handle an oral medication while dispensing it. Staff should use either the top of the pill container or a disposable small paper cup, and they should measure liquid medications with an exact measuring device.

Responsibility for Reporting for Medication

Although school district policy may state that it is the student's responsibility to report for medication, it is advisable that the person responsible for adminstering medications make a concerted effort to locate students who do not report. While a delay in the administration of many medications may not cause an adverse medical reaction, such possibilities make it incumbent upon the district to do all it can to avoid such a possibility and, of course, any resulting liability.

Medication Error

Most medication errors occur when an individual is interrupted or distracted during the administration of medication or has simultaneous primary responsibility for a task other than medication distribution. Eliminating distractions and other responsibilities during periods of concentrated medication administration can increase safety and accuracy and decrease the potential for errors.

In the event of a medication error of commission or omission, the person who administered the medication should immediately

- assess the student;
- notify the school nurse, a supervisor, or school administrator;
- contact the Poison Control Center, if necessary;
- notify the student's parent(s);
- notify the student's physician; and
- complete a written report of medication error detailing the student's name, parent's or guardian's name and phone number, specific statement of the medication error, people notified, and remedial actions taken.

Appendix L ("Medication Incident Report Form") offers districts a sample for adoption or adaptation in creating a medication incident report form.

Notification of Staff Members

In view of the rights of children and families to confidentiality of health-care information, school districts must consider what provisions will be made for notifying classroom teachers of students who need medication. Teachers who are given such information should be reminded that it must, by law, remain confidential.

Medication Administration and Documentation

Training

Where possible, school nurses should train at least two nonprofessional school health personnel (one as a primary assistant and the other(s) as back-up assistants) to administer medications in the event the nurse or designated or delegated assistant is absent or needs regular assistance. The nurse should provide nonprofessional school health personnel with a complete orientation, covering

- legal issues surrounding medication administration,
- techniques for properly dispensing and storing medications,
- necessary documentation,
- responsibilities for locating students who fail to report, and
- contact people for immediate help with questions or medication errors.

Appendix M ("Documentation of Medication Administration Training and Monitoring") offers guidelines, in accordance with relevant laws, for documenting a district's initiatives to train and monitor those people who administer oral medications.

Documentation

A medication record should be kept for each student receiving medication at school. This log should include the

- student's name, address, and phone number
- name of the drug
- dose the student should take
- frequency/time of administration
- date
- date the medication expires ("shelf life")
- name of the administering person

So that it is easily accessible, this log should be kept with the parental consent and physician's order for medication forms. At the end of the school year, individual medication administration logs should be filed in the pupil physical health record.

Nurses, working with administrators, should design the documentation so that it describes each school day's activities as they relate to medications or procedures. In the event that the medication is not administered as prescribed, the person responsible for administering it should indicate if the student

- was absent from school,
- refused medication, or
- did not report/was not located for medication.

It is important to note that most prescription medications will not expire before they are fully used. As-needed medications, however, are more likely to expire during the school year. In either case, nurses should check medication bottles throughout the year to prevent the inadvertent use of expired medications. When such a bottle is found (or preferably beforehand), the nurse should notify the student's parents to discuss discarding or replenishing the medication in a timely manner.

The sample "Student Medication Administration Log and Procedures" (Appendix N) may serve as a helpful guide to districts wishing to develop or revise their own logs.

Types of Medication

Nonoral Medications

State law makes it clear that no school employee can be required to administer nonoral medications as a condition of employment. However, under the delegation/direction of a nurse, staff members wishing to do so may be trained to administer medications by means other than or in addition to oral ingestion.

In either case, the district and nurse will want to carefully consider whether a medication can, in each given circumstance, be given safely by a staff member who is not a licensed health-care professional.

EpiPens are auto-injectors that deliver a set dose of epinephrine during a life-threatening (anaphylactic) reaction to a bee sting or other allergen. School nurses may legally delegate, train, monitor, and supervise teachers and other non-

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professional school health personnel for this task, if they are willing and able to accept the delegation from the nurse. As EpiPens are nonoral medications, staff members may not be compelled to administer such injections.

Over-the-Counter Medications

While state laws permit the administration of nonprescription medications with written instructions and parental consent, each district must consider how it will handle over-the-counter (OTC) medications. Though OTC's have a legitimate place in providing health care in the school setting, districts should not administer them casually. Like any other medication, OTC medications are potentially hazardous to the health of students, depending on the quantity given, potential side effects, interactions with other medications, and other unfavorable reactions. Consider, for example, the following:

- Many people rely on OTC medications for conditions that, if investigated, might have simpler solutions. For instance, a child's headache may be the result of not eating properly and developing hypoglycemia. Dispensing an OTC medication will not improve the underlying cause, which is hunger.
- Recent studies linking aspirin to Reye's Syndrome in young children demonstrate that there are areas of drug reactions in children for which there is little information.

The school district exposes itself to the least amount of risk by requiring written parental consent and a physician's order for both nonprescription and prescription medications. Districts which allow for the use of nonprescription drugs with written parental consent only should make it clear who—the student or a trained staff member (most advisable)—will administer the medications.

The Wisconsin Board of Nursing governs administration of OTC medications by nurses. School nurses may administer OTC medications to students based on standing orders developed in collaboration with the district's medical advisor, provided that the school board allows the use of such standing orders.

As-Needed Medications

As-needed (PRN) medications may or may not be prescription drugs. This type of medication order can often pose difficulty for school districts because students often require the medication only in specific situations indicated by specific clinical signs and symptoms.

In complex situations, ones in which substantial nursing skill, knowledge, training, and application of nursing principles are required to make a decision, the school principal should work collaboratively with the school nurse to determine which PRN medications should or should not be delegated for administration by a trained staff member.

When a student's clinical condition is not predictable—as with a seizure disorder—or when nursing procedures are likely to involve frequent or complex modifications (medications should only be given after a seizure lasts a given length of time), the nurse cannot delegate the assessment and evaluation functions in their entirety to licensed practical nurses or less-skilled assistants. In such circumstances, the nurse needs to assess the medication order and determine which aspects of assessment, intervention, and evaluation of the student's response to the medication can be delegated safely.

Self-Administered Medications

While some students may be able to self-administer medications in the prescribed manner without assistance, it may be prudent under certain circumstances for the school district to store even that medication in the health office or another designated location. It would be advisible for districts to consider each request to self-administer medication in consultation with the student, parent(s), physician, and nurse to determine whether the student is capable of self-administering needed medication in the school setting.

In addition, some children may need to carry their medication, such as an inhaler or EpiPen, throughout the day, including on the school bus. This stance is supported by a 1991 position statement from the Committee on Drugs of the American Academy of Allergy and Immunology.

Effective September 1, 1999, Wisconsin Act 77 is consistent with this stance. This statute allows asthmatic students to carry and self-administer inhalers at school or school-sponsored activities, with approval of the student's physician *and* parent or guardian on file at the school. Furthermore, this law notes that the school district, school board, or school employee is immune from civil liability for prohibiting a student to use an inhaler because of a good faith belief that the approvals have not been obtained and are not on file at the school or for allowing a student to use an inhaler because of a good faith belief that the approvals have been obtained and are on file at the school.

Controlled Substances

The Drug Enforcement Administration categorizes controlled substances by schedules based on the potential for abuse or dependence.

While some medications students take at school will be in schedules 3, 4, or 5, which pose little or no potential for abuse or dependence, some medications—such as Ritalin (methylphenidate) or dexedrine, both used to treat Attention Deficit Hyperactivity Disorder—may be classified as Schedule 2 medications, meaning they have potential risk for abuse or dependence.

Wisconsin's Uniform Controlled Substances Act (Wis. Stat. 151) regulates the prescription of Schedule 2 drugs in many ways. School districts should consider this type of medication carefully when planning for the transportation of medications and refills to school, their storage, and administration during co-curricular or extracurricular activities.

Special Orders

Parental Request for Order Change

Parental requests to change a prescription medication order (dose or time of administration) must be approved by the prescribing physician before they can be implemented. Parental requests to change an OTC medication may be evaluated based on dosing information contained on the manufacturer's label. Districts will want to consider the procedure by which such requests are processed.

Verbal Orders

Districts must decide whether they will accept verbal orders from physicians or other qualified health-care professionals for medication and other health-care procedures. If they do so, districts should also decide how such orders will be documented (that is, by faxing or mailing a copy of the medication order). *Only a registered nurse can accept verbal orders.*

Non-Wisconsin Licensed Physicians

Wisconsin Act 181 (1991) amended the state's Nurse Practice Act (Wis. Stat. 441) to allow nurses to accept and carry out orders from a physician, podiatrist, or dentist not licensed in Wisconsin, but licensed in another state. However, the amended law requires that the physician, podiatrist, or dentist examine the patient in the other state and then prepare an order to be carried out in Wisconsin.

It is essential that the district verify licensure of any so-defined physician, podiatrist, or dentist before carrying out medication-administration orders. The Wisconsin Board of Nursing developed

Figure 20

Verification of Licensure of Non-Wisconsin Licensed Physicians, Podiatrists, or Dentists

- Verification of licensure of a physician, podiatrist, or dentist in another state should be done by the employer (for example, the school district or contracted agency).
- Before any order is carried out by the nurse, verification should be obtained and documented, including how and when it was obtained.
- It should be documented that the patient was examined in the other state by the physician, podiatrist, or dentist.
- For verification related to home care, the Unique Physician Identification Number (UPIN) may be used. For verification related to other settings, agencies, or facilities, the licensing board for physicians, podiatrists, or dentists in other states may be contacted.
- Professional judgement must be exercised by the nurse in assessing the patient's condition and in determining whether the patient must return to the other state to be seen by a physician, podiatrist, or dentist for new orders.

Approved 10/29/92—Wisconsin Board of Nursing a set of recommendations for agencies, employers, and nurses to follow when verifying the licensure of such health-care providers (see Figure 20). School administrators, in conjunction with the school nurse, are responsible for verifying licensure.

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Child Protection 6

Introduction

Child abuse is recognized by many as one of the most serious issues facing our nation's children. Mental health officials have identified child abuse or neglect as underlying motivation for later substance abuse and attempts at suicide by those who were youthful victims of such abuse or neglect. Furthermore, studies of criminal behavior also indicate that people who were abused as children are responsible, as adult perpetrators, for a high percentage of child abuse incidents.

Historically, the full scope of the child abuse problem is difficult to assess, since many incidents are never reported. However, as the American people have become more informed about the problems of child abuse and neglect, it is believed that reports of such incidents have become more consistent and frequent.

In 1995, according to the *Wisconsin Child Abuse and Neglect Annual Report* (Wisconsin Department of Health and Family Services, 1996), child welfare agencies nationwide received reports of approximately 2.9 million children being mistreated. The same year, Wisconsin counties reported suspected abuse or neglect of 44,661 children. Neglect accounted for 20,721 of those reports, followed by 15,654 reports of physical abuse. There were 11,148 reports of sexual abuse, and 1,161 reports of emotional abuse. Approximately 38 percent of reports were substantiated as abuse or neglect. (Note: The sum of the numbers for each type of abuse exceeds the total number of abuse reports, as some reports included allegations of more than one type of abuse.)

According to the recently released *Child Maltreatment 1996: Reports from the States to the National Child Abuse and Neglect Data System*, record levels of child abuse and neglect continue in the United States. Nearly one million children were validated as victims of child abuse or neglect in 1996, and an estimated 1,077 children died in 1996 as a result of abuse or neglect. Other findings include the following:

- Parents are the chief perpetrators.
- Children under the age of three account for three-quarters of deaths due to abuse or neglect.
- Fifty-two percent of victims were girls and 48 percent were boys.
- Fifty-three percent of the victims were white; 27 percent were African-American; 11 percent were Hispanic; 4 percent Asian/Pacific Islander; and 2 percent Native American.
- Fifty-two percent of maltreated children suffered neglect; 24 percent were physically abused; 12 percent were sexually abused; 6 percent suffered emotional abuse; 3 percent were medically neglected; and 16 percent were subjected to other forms of maltreatment.

Due to the potentially volatile and life-changing nature of true or false allegations of abuse or neglect, it is important for school nurses and staff members to consider their own background and experience with such incidents. That is an especially important exercise should the nurse or staff member be a former or current victim of abuse or neglect. If such is/was the case, the nurse or staff member should carefully consider whether such circumstances might inappropriately affect their ability to fairly and effectively deal with such incidents in the lives of the children and families they serve.

This chapter will help school nurses and staff members

- prepare to report, as required by law, suspected cases that come to their attention.
- better understand *disclosure, documentation, reporting, investigation,* and *follow-up.*
- develop relationships with community resources to assist children and their families.
- increase and/or assess their knowledge of risk factors and symptoms of abuse and neglect as well as their personal beliefs and experiences related to abuse issues.
- know when, where, and to whom to report suspected incidents of abuse or neglect.
- understand the statutory requirement to report as well as exceptions to that mandate.
- develop and/or review, in cooperation with district administrators, student-services colleagues, and other partners, existing school district child protection policies, procedures, and reporting tools to assess compliance with local procedures and state laws.
- understand the local child-protection agency's investigative process and have ready access to its phone number and hours of operation.
- appreciate the value of attending child abuse and neglect prevention workshops, reading related materials, and networking with health and human services colleagues in related community agencies and organizations.
- create formal and informal opportunities to present students, parents, and school staff members with information on preventing, identifying, and reporting suspected or actual child abuse and neglect.

These goals will be met, in part, by addressing:

- the role of the school nurse;
- legal considerations,
- special considerations,
- sexual abuse,
- disclosure,
- mandatory reporting, and
- transition beyond the school.

The Role of the School Nurse

The school nurse fills a variety of roles in the lives of children who are victims or are at risk of becoming victims of abuse and neglect. As a trained professional, the school nurse is uniquely equipped to address a student's physical and emotional needs. In fact, in many educational settings, the nurse may be the only member of a school's student-services team capable of effectively assessing *both* the physical and emotional needs of students.

Assessment focuses on identifying signs or symptoms of physical or emotional trauma, especially the possibility of a sexually transmitted disease or pregnancy; such acute situations will demand immediate medical attention and evaluation as well as mandatory reporting. In such serious cases, children will need particular reassurance and support to calm the thoughts and fears they may have regarding what you have discovered and its possible effect on them.

In light of the possibility of encountering such crucial, life-changing circumstances in the life of a child, it should go without saying that, just as school nurses must be trained and conversant in the daily tasks of traditional nursing, they should be informed and trained for the important work of identifying situations of possible abuse or neglect. In order to effectively assess students, school nurses must

- know the risk factors, signs, and symptoms of abuse and neglect;
- familiarize themselves with the cultural and ethnic norms of children and their families in the school community; and
- be able to identify the school and community resources which may be useful.

Through individual health room contacts, the development and delivery of health education and health-screening programs, and school-age parenting programs, nurses can identify children at risk for or experiencing abuse or neglect. Symptoms of abuse and neglect often vary with the developmental age of the child. To assist nurses in recognizing such symptoms, Figure 21 lists common indicators of physical abuse, emotional abuse, and neglect in the school-age child.

Community Awareness

School nurses also have the opportunity to extend others' understanding and identification of child abuse and neglect by providing information to groups of students, school staff, parents, and others in the community who may, in turn, identify children who are suspected of being abused or are at risk of being abused. These potential reporters may also be instructed in how to encourage children to self-report such incidents. The school nurse encourages and enhances such awareness efforts by working with classroom teachers to

Figure 21

Abuse and Neglect

Physical Abuse

Physical Indicators

Unexplained bruises and welts
- on face, lips, mouth, on torso, back, buttocks, and thighs
- in various stages of healing
- clustered, forming regular patterns
- reflecting shape of article used to inflict (electric cord, belt buckle)
- on several different surface areas
- observed regularly after absence, weekends, or vacation

Unexplained
- cigar or cigarette burns, especially on soles, palms, back, or buttocks
- immersion burns (sock-like, glove-like, doughnut shaped on buttocks or genitals)
- patterned, like electric burner, iron, and so forth
- rope burns on arms, legs, neck, or torso

Unexplained fractures
- to skull, nose, facial structure
- in various stages of healing
- multiple or spiral fractures

Unexplained lacerations or abrasions
- to mouth, lips, gums, eyes
- to external genitals

Behavioral Indicators

- Wary of adult contacts
- Apprehensive when other children cry
- Behavioral extremes (aggressiveness or withdrawal)
- Frightened of parents
- Afraid to go home
- Reports injury by parents

Neglect

Physical Indicators

- Consistent hunger, poor hygiene, inadequate or inappropriate dress
- Consistent lack of supervision, especially in dangerous activities or for long periods
- Unattended physical problems or needs
- Abandonment

Behavioral Indicators

- Begging, stealing food
- Extended stays at school (early arrival and late departure)
- Constant fatigue, listlessness, or falling asleep in class
- Alcohol or drug abuse
- Delinquency
- States there is no caretaker

Emotional Abuse

Physical Indicators

- Speech disorders
- Lags in physical development
- Failure to thrive

Behavioral Indicators

- Habit disorders (sucking, biting, rocking)
- Conduct disorders (antisocial, destructive)
- Sleep disorders, inhibition of play
- Psychoneurotic reactions (hysteria, obsession, compulsion, phobias, hypochondria)
- Behavior extremes (compliant, passive, aggressive, demanding)
- Overly adaptive behavior: inappropriately adult (parenting other children) or inappropriately infantile (head banging, rocking, thumb-sucking)
- Developmental lags (physical, emotional, intellectual)
- Attempted suicide

Source: Reprinted with permission from the North Carolina Department of Health and Human Services. North Carolina School Health Manual. *Raleigh: NCDHHS, 1991, pp. 34-36.*

- educate children about the human body,
- help children distinguish between appropriate and inappropriate touching,
- develop in children an awareness of potentially unsafe situations, and
- instill in children a confidence to assert themselves to prevent or report such unsafe conditions or related abuse.

School nurses have the opportunity to observe and assess children with known histories of abuse and determine how they are coping and managing on a regular basis. Some children may live in potentially unsafe environments, where their emotional needs might change over time.

Furthermore, the emotional impact of child abuse and neglect often carries beyond the neglected or abused child to siblings and classmates. Nurses have the opportunity to extend their observation and assess the effect of the abuse on other students.

Nurses who can observe, monitor, and, when necessary, make referrals for treatment and intervention will facilitate the healing process and ensure the child's safety, even as they are promoting the child's well-being and academic success.

School and Community Resources

Child abuse prevention requires the development of healthy human relationships, caring families, and supportive communities. A school nurse's ability to identify and mobilize the school's and the community's resources can support child abuse and neglect prevention efforts.

Because school nurses gather information through health assessments and by consulting with students, parents, administrators, teachers, and other student-services providers, they have a unique perspective from which to recommend to families specific community resources that can help them effectively meet the needs of the child and the family.

As with any effort, it is critical to establish cooperative working relationships with related community agencies and/or service providers before an alleged case of abuse or neglect arises. There are several ways to establish such relationships:

- In cooperation with community agencies and/or service providers, disseminate information related to the causes, identification, and treatment of child abuse and neglect to school colleagues, parents, and community members.
- Work with school colleagues and community-service providers to develop an effective prevention education program and an abuse/neglect reporting system.
- Maximize school district resources, which may include health education and school-age parent curricula, extracurricular activities, student-school staff relationships, and school environment.
- Maximize community resources, which might include: community education programs on parenting; after-school and summer school activities; and job- or community-service opportunities.
- Develop school- and community-based partnerships, which may include a network of parents, educators, and other professionals whose ethnic background or training offers special insights into an identifiable portion of the student body.

Legal Considerations

In 1977, the Wisconsin legislature revised the Wisconsin Child Abuse and Neglect Act, containing all of the statutes relating to child abuse or neglect (except for sexual abuse); Wis. Stat. 48 is referred to as the Children's Code. The Code's purpose is to protect the health and welfare of children by encouraging educators, parents, social service agencies, and others to effectively prevent and/or report cases of abuse and neglect.

The Children's Code defines child abuse and neglect and details the responsibilities of officials in the child protective services agency.

- *Physical abuse* is any physical injury inflicted on a child by other than accidental means. Physical injury means, but is not limited to, lacerations, fractured bones, burns, internal injuries, and severe or frequent bruising (Wis. Stat. 939.22(14)).
- *Emotional abuse* is harm to a child's psychological or intellectual functioning which is exhibited by extreme anxiety, depression, withdrawal, outward aggressive behavior, or a combination of these behaviors, for which the parent, legal guardian, or other legal custodian has failed to obtain the necessary treatment to remedy harm (Wis. Stat. 48.981(1)(cm)). Emotional damage may be demonstrated by observable changes in behavior, emotional response, or learning that is incompatible with the child's age or stage of development.
- *Neglect* is the failure by a parent, legal guardian, or caretaker, exercising temporary or permanent control over the child, for reasons other than poverty, to provide necessary care, food, clothing, medical or dental care, or shelter so as to seriously endanger the physical health of the child.

This includes failure to provide appropriate supervision of children (Wis. Stat. 48.981(1)(d)).

Although not covered by the Children's Code, *sexual abuse* has a legal definition (Wis. Stat. 948) that is directly linked with the others. Sexual abuse includes

- sexual intercourse or contact (Wis. Stat. 948.02);
- sexual exploitation (Wis. Stat. 948.05);
- permitting, allowing, or encouraging a child to engage in prostitution (Wis. Stat. 944.30);
- the use or threat of force or violence (Wis. Stat. 940.227);
- causing a child to view sexually explicit materials or behavior (Wis. Stat. 940.227); and/or
- any contact, over or under clothing, with a sexual part of the body of a child who has not attained the age of 16 years (Wis. Stat. 948.02).

Special Considerations

While volumes have been written on this topic, this section highlights just a few of the areas relevant to the daily work of the school nurse and staff members, who are encouraged to pursue additional resources to increase their awareness of risk factors, signs, and symptoms that they may encounter in their work with students.

Children with Special Health-Care Needs

Generally, the younger the child, the greater their vulnerability to abuse and neglect. This holds true especially for children with physical and cognitive disabilities and for the medically fragile. Their risk may be increased because they are more dependent on their care givers (often more than one) to meet their daily needs and because they may have difficulty communicating. As a result, they may be perceived as "easier" victims because they may be seen as less likely to report (Murphy, 1993).

In addition, while most families of children with special needs cope quite well, some of these children may be at greater risk because the demands on parents or care givers to provide daily care for the child may cause greater stress than the care givers can handle. If these families also have basic problems with parenting skills, the child's increased needs may exacerbate those problems and lead to neglect or abuse. School nurses who care for or supervise staff caring for children with special health-care needs should be aware of the increased risk for these children and provide them and their families with information and access to available support and services.

As a consultant to teachers working with special-needs populations, the school nurse can locate and provide resources that teach children with special needs how to protect themselves. Such resources may include the "Skills Training for Assertiveness, Relationship Building, and Sexual Awareness" (STARS) curriculum (Heighway, Webster, and Shaw, 1992) developed at the Waisman Center in Madison.

Cultural and Ethnic Issues

Wisconsin schools are now the "academic homes" to a more ethnically diverse population than ever before. The vast cultural differences in such schools present myriad different traditions of discipline, child care, and medical care.

When considering the possibility of child abuse, the nurse needs to consider the child-rearing and discipline practices of the culture from which the child comes. For instance, the Hmong, immigrants from Southeast Asia, are known for a practice called coining (which is believed to have originated in China). In coining, the body is rubbed with a coin to alleviate pain. The bruises this practice leaves on the body may resemble the marks of child abuse.

Working with the parents and ethnic leaders to help them understand the rights of children in America may help ensure the safety of children by providing the parents with information that may help them modify cultural practices.

Sexual Abuse

Sexual abuse is a unique form of violence against children which is seldom discussed and often poorly understood. Inappropriate sexual contact has lasting negative effects on children and their development. Because of the strong feelings many people have regarding sexual abuse, dealing with the problem in a compassionate and rational way can sometimes be difficult.

Based in great part on disclosure by victims, it is estimated that 25 percent of women and 10 percent of men have been sexually abused or assaulted. While girls are more likely to be abused by family members, boys tend to be abused by people outside their homes (Murphy, 1993).

Physical and behavior symptoms are most common in early childhood. School-age children are more likely to exhibit psychosomatic and behavioral disturbances. Teenagers may exhibit behavioral, psychosomatic, and psychiatric symptoms (see Figure 22).

Exception to Mandatory Reporting

Wis. Stat. 48.981(2m) provides an exception to reporting incidents of sexual contact between individuals under the age of 16.

The exception exists to allow children to obtain confidential health-care services from a health-care provider. The statute specifically defines such providers as physicians, physician's assistants, and registered nurses. In essence, the exception notes that such providers are not required to report sexual intercourse or sexual contact involving a child under the age of 16 *unless*:

- the sexual intercourse or sexual contact that occurred or is likely to occur is with a relative of the child, the child's guardian or legal custodian, or a person who provides care or supervision of the child;
- the child—because of age, maturity, mental illness, or mental deficiency—is incapable of understanding the nature/consequences of sexual intercourse or contact;
- the child was unconscious at the time;
- the other participant was exploiting the child at the time; and/or
- reasonable doubt exists as to the voluntary nature of the child's participation in the sexual intercourse or sexual contact.

Depending on the nature of a relationship, sexual contact between teens under the age of 16 may or may not be considered abusive. Regardless, state statutes require that any sexual contact with or between children under the age of 16 must be reported to the county child protection services (CPS) by all mandated reporters except as stated in 48.981(2m) and (2m)(4).

Each CPS agency has been granted a degree of latitude in determining how it will address consensual sexual contact between children under the age of 16. However, state law proscribes specific action for nonconsensual acts between children under the age of 16. Since the CPS agency decides whether to investigate such allegations, this is an issue that school administrators, school nurses, and other student-services providers should collectively and proactively address with legal counsel and local department of social services to learn how the county may deal with such reports. The CPS Investigation Standards set forth the following questions to provide a framework for such determinations:

- Was the sexual contact in any way coercive or harmful to the involved child?
- Did parental action or inaction contribute to an incident which may be harmful to the child?
- Is support for the parents' role in providing protection and services needed?

It is important for school nurses to note that an exception to mandatory reporting exists for nurses providing *health-care services* (Wis. Stat. 48.981(2m)). Those services are defined as:

- family-planning services
- pregnancy testing
- obstetrical health care
- screening diagnosis and treatment of sexually transmitted diseases

Additionally a reporting exception exists for people who obtain information about a child who is receiving or has received health-care services from a health-care provider (Wis. Stat. 48.981 (2m)(4)).

By the very nature of any one of these services, a nurse may learn of a child having sexual intercourse or of sexual contact between two children under the age of 16. Should such a discovery be made, the nurse is not required to report these incidents as suspected or threatened abuse *unless there is reason to believe that the child is being harmed by this contact*. The law presumes harm to a child exists when there is sexual contact with a care giver or exploitation of a child in any way (including exploitation of one who is handicapped, unconscious, or suffering from mental illness).

If there is any question as to whether a child was a willing participant in such an incident, it *should be* reported (Wis. Stat. 48.981(2m)).

Disclosure

Two basic types of disclosure relate to reporting child abuse and neglect. The first is *informal disclosure*, which is often done by the child. The second is *formal disclosure*, which occurs between adults addressing allegations of abuse or neglect.

Informal Disclosure

A child's description of an experience(s) is a type of *informal disclosure*, generally an informal discussion or presentation of symptoms.

Figure 22

Sexual Abuse

Early Childhood Indicators

Physical Symptoms

- Sexually transmitted disease
- Unexplained bruises of or bleeding or discharge from external parts of vagina or anus
- Complaints of irritation, pain, or injury to the genital area
- Difficulty walking or sitting due to genital or anal pain
- Unexplained, recurrent urinary tract infections

Psychosomatic Symptoms

- Onset of daywetting or enuresis
- Encopresis (fecal soiling)
- Sleeping or eating disturbances

Behavioral Symptoms

- Excessive fears or phobias (e.g., of males.)
- Age-inappropriate behavior
- Compulsive masturbation (interruption of play to masturbate, especially chronic or in public; female involving vaginal penetration)
- Inappropriate, unusual, or aggressive sexual behavior (pretending oral, vaginal, anal penetration with dolls, playmates, animals)
- Excessive curiosity about sexual matters or private parts (self and others)
- Detailed and age-inappropriate understanding of sexual behavior
- Aggressive, out-of-control behavior

School-Age Indicators

Physical Symptoms

- Sexually transmitted disease
- Unexplained bruises of or bleeding or discharge from external parts of vagina or anus
- Complaints of irritation, pain, or injury to the genital area
- Difficulty walking or sitting due to genital or anal pain
- Unexplained, recurrent urinary tract infections

Psychosomatic Symptoms

- Recurrent abdominal pain
- Headaches
- Sleeping or eating disturbances
- Depression
- Encopresis (fecal soiling)
- Enuresis

Behavioral Symptoms

- Sexually provocative behavior
- School problems or significant change in school performance (attitudes, grades, frequent absences)
- Expressed feelings of depression, shame, humiliation, guilt, betrayal, self-hate
- Social withdrawal
- Abnormally self-conscious of body
- Acting out, runaway, aggressive, out-of-control
- Lack of friendships with others their own age, poor social skills, inability to make friends

Adolescent Indicators

Physical Symptoms

- Sexually transmitted disease in a child under age 13
- Unexplained pregnancy or attempts to conceal a pregnancy
- Unexplained bruises of or bleeding or discharge from external parts of vagina or anus
- Complaints of irritation, pain, or injury to the genital area
- Difficulty walking or sitting due to genital or anal pain

Psychosomatic Symptoms

- Recurrent abdominal pain
- Headaches
- Sleeping or eating disturbances
- Depression

Behavioral Symptoms

- Promiscuity
- Alcohol or drug abuse
- Running away
- School problems or significant change in school performance (attitudes, grades, truancy)
- Expressed feelings of depression, shame, humiliation, guilt, betrayal, self-hate
- Social withdrawal
- Lack of friendships with others their own age

Psychiatric Symptoms

- Self-mutilation
- Suicide attempts
- Bulimia

Source: Adapted from Murphy, J., "Child Sexual Abuse," Journal of School Nursing *(October 1993): 33.*

In order to determine whether suspected abuse or neglect has occurred, it is important to gather as much information as the child is willing to give (NASN, 1995). It is important to ask open-ended questions that elicit, in the child's own words, what has happened, rather than ones which can be answered with a simple "yes" or "no." Often students will spontaneously reveal what happened to them if a staff member, when observing, for example, bruises or marks, remains calm and inquires sensitively. It is also helpful to learn who may have observed the incident.

School staff members who discover and disclose potential child neglect and abuse must play a crucial role in supporting the child through any subsequent investigation. The success of such efforts is more likely when staff members follow the "Guidelines for Disclosure" (see Figure 23).

It is most important to let the child know that she or he did the right thing by telling someone about what has happened. No matter what actions the specific incident necessitates, the adult should communicate four main messages:

- I believe you.
- I will help you.
- I still like you.
- What happened was not your fault.

Formal Disclosure

Such informal disclosure usually leads to *formal disclosure*, which involves the transfer of information among adults, either within the school or among agencies. In the *Child Abuse and Neglect Prevention Guide* (WDPI, 1993), Berkan and Kadushin describe formal disclosure as follows:

> "Federal and state law limits the school's disclosure regarding a minor student by directing that parental consent must first be obtained. The Family Educational Rights and Privacy Act (FERPA), 20 U.S.C. 1232g, 34 Code of Federal Regulations (CFR) 99, is the relevant federal law. The state law that deals with parental consent is 118.125, Stats. Two exceptions to limited disclosure are made: school staff who need the information about a child may obtain it; information may be shared with "appropriate parties" as defined by FERPA, to protect the child's safety and welfare. The school, when dealing with a referral for suspected child neglect or abuse, must carefully apply this second exception to meet the needs of the student and the federal and state regulations. In situations where the decision to share information is unclear, the

Figure 23

Guidelines for Disclosure

- Find a quiet and private place to talk with the child.
- Maintain eye contact and convey concern and respect for the child.
- Under circumstances in which reporting is not mandated, assure the child the conversation will remain confidential.
- Remain calm; do not express shock or panic.
- Listen to the child.
- Express belief that the child is telling the truth.
- Try to get the facts of the situation from the child's point of view.
- Use language the child can understand. Helpful questions include: *What happened to you? Who did this to you? How did this happen? Where did this happen? When did this happen? Who saw this happen to you? Have you told anyone else about this?*
- Reassure the child that what happened is not his or her fault and that he or she is not "bad."
- Tell the child you will do your best to protect and support her or him.
- Determine the child's immediate need for safety.
- Report the incident to the local child protection or law enforcement agency.
- Let the child know what will happen when the report is made.

Sources: Child Abuse and Neglect Prevention, *Wisconsin Department of Public Instruction, 1993;* Educator's Handbook on Child Abuse, *Sheboygan Area School District, 1990;* Orientation Manual, *National Association of School Nurses, 1995.*

> child protection worker may request the court to provide the school with an order for the disclosure of additional information. Such an order relieves the school of the prohibition against sharing information and allows the school to collaborate with the child protection agency. Sec. 118.126 Stats., further restricts the pupil service staff from sharing any AODA-related information that they receive from or about the student."

In summary, the CPS intake worker has a right to information which has a bearing on the investigation. However, no provision is made in Wis. Stat. 48, Wis. Stat. 118.125, or FERPA allowing the release of student records without parental consent or a court order. School staff are advised to cooperate with oral interviews.

Obstacles to Reporting

The problem of child abuse reporting is compounded by the potentially volatile and sensitive nature of such incidents. Many potential reporters may feel compelled to turn back from the daunting task of "juggling" four related concerns, any of which, if "dropped" or not handled with due diligence and care, has the potential to shatter the life of a student and family relationships. Those concerns are the

- rights of the parents,
- needs of the child,
- sanctity of the home, and
- responsibility to protect children.

As one can easily imagine, the inter-relationship among these concerns—each of which is sometimes fraught with its own unique internal philosophical and legal conflicts—demand deft balancing skills. Similarly, they also demand from a potential reporter a firm commitment to face all of the challenges brought on by any ensuing battle over community involvement, parent rights, and children's needs.

One underlying issue—that of spanking or corporal punishment by a parent or an educator—underscores this predicament. The debate continues as to whether spanking or other physical punishment is an acceptable means of child discipline. Even when agreement may exist on the broader issue, sharp disagreement may occur over the age at which it is reasonable to begin or discontinue such measures. Similarly, little consensus has been reached regarding the age at which it is safe to leave a child home unsupervised.

While communities usually become interested or involved in such related debates only after the public revelation of a very serious related case (WDPI, 1993), legal organizations and social agencies resist codifying such disciplinary or "Home Alone" standards for fear that they will be interpreted as an attack on the rights of parents. Reticence on the part of policy makers to codify is, in part, rooted in the prevalent underlying assumption that, by "human nature," parents usually have the best interests of their children in mind and that they will usually act in a reasonable manner in support of those interests.

Understandably, confusion about the role of the child welfare system may emerge as it seeks to balance related concerns—parental rights, children's needs, sanctity of the home, and a responsibility to protect children—while providing troubled families with assistance and treatment to remedy problems and decreasing the risk for mistreatment in the least intrusive manner possible (Wisconsin Department of Health and Social Services, 1994). The potential for confusion underscores the need for school personnel, local health departments, physicians, and social service agencies to work together to protect the health and welfare of children when abuse or neglect is suspected.

Mandatory Reporting

Because children spend a large portion of their time in schools, school nurses and staff members have the opportunity to observe first-hand the symptoms of possible abuse and neglect and to become a part of the reporting process. Schools are currently the second largest source of reports of child abuse and neglect.

Well before a school nurse or other staff members observe signs of potential abuse or neglect, it is essential that they become aware of the requirements of Wisconsin's Children's Code (Chapter 48). It requires that teachers, administrators, nurses, and social workers, among others, report suspected abuse and neglect to the county child protective agency or sheriff's department for assessment. Figure 20 ("Guidelines for Disclosure") recommends steps school staff members should take when they learn of a suspected incident of abuse or neglect which falls under the statutory mandate for reporting. The Children's Code refers to such people as "mandated reporters" and states that they—having seen a child during the normal course of professional duties and having a reasonable suspicion that abuse and neglect may have occurred or a reasonable belief that abuse or neglect will occur—must report such an incident. Failure to do so can result in a fine up to $1,000, or imprisonment for not more than six months, or both. Requesting another person—whether a teacher, social worker, administrator, or someone else—to make the report does not absolve one from the legal responsibility of reporting. Any person making a report in good faith is granted immunity from civil or criminal liability.

It is important to note that a mandated reporter is not required to complete an assessment to substantiate whether an actual case of abuse or neglect exists. The responsibility for such investigation and determination rests with the child protection agency. However, the mandated reporter will need to gather information to support any reasonable suspicion. When the validity of such allegations is uncertain, those adults listed in the Children's Code must report the incident to the local CPS.

School nurses and staff members play an important role in reporting abuse and neglect of children in Wisconsin. According to the "Annual Report to the Governor and Legislature on the Wisconsin Child Abuse and Neglect Act" (Department of Health and Family Services, 1996), reporters of child abuse in 1995 were:

- school counselors–9.2 percent of all reports
- teachers–4.4 percent,
- school administrators–3.0 percent,
- nurses (not limited to school nurses)–2.8 percent
- the abused child–1.5 percent

By way of comparison, the following ranked among the highest percentage of all reporters:

- law enforcement–16.2 percent
- a social worker–10.8 percent
- a parent of the child victim–10.1 percent
- anonymous–9.1 percent
- other relatives of a child victim–8.1 percent
- a neighbor/friend–7.5 percent
- other–5.6 percent
- a mental-health professional–4.7 percent

Among the lowest were physicians (1.4) and perpetrators (0.2).

Eight other categories of reporters accounted for less than 1 percent each, and seven categories of potential reporters accounted for no reports.

In spite of the fact that students spend such a significant part of their lives in school, professionals from that environment accounted for only 16.6 percent of all reports of child abuse and neglect in 1995 (down from 18 percent in 1993). Furthermore, they ranked in the bottom third of all those (by category) who report such incidents.

Still, school nurses and other staff members are doing much and can do more to ameliorate such problems in the lives of the young people and families they serve.

School Reporting Policies

Schools may have specific abuse reporting policies that school nurses and staff members should follow (see Appendix O), "Abuse Reporting: Basic Elements of School District Policies"). If guidelines do not exist or seem vague, mandated reporters should inform administrators of the state's mandatory reporting statutes. (For a more extensive discussion, see *Child Abuse and Neglect Prevention*, Wisconsin Department of Public Instruction, 1993.) Some schools require the administrator to make mandatory reports. Even in such circumstances, school staff members still have a statutory obligation to file their own report.

It is important to note that reports of suspected abuse and neglect need to remain confidential. While they do not become a part of the child's school records, they may be kept within the school in a separate file. Because of the sensitive and confidential nature of such allegations and reports, school districts should consider relevant statutes in answering the following questions:

- What records should be kept?
- Where should such records be kept?
- How long should such records be kept?
- Who will be responsible for such records?

It is especially important to remember that the state presumes that anyone making a report does so in good faith, thus exempting the mandatory reporter from liability as a result of a report.

A nurse contracted by the school from a local health department, hospital, agency, or other organization must follow their employer's guidelines unless specified in a protocol between the school district and the contracting organization. The nurse who finds it necessary to make a report to the CPS agency of suspected abuse or neglect should also inform the school principal that such a report has been made.

Regardless of the employer, good communication between the school staff and the nurse, with an awareness of the need for confidentiality, allows all adults to support the student during the investigation. Again, even if there is disagreement among members of the school team, any reasonable suspicion that abuse or neglect has occurred must be reported (Murphy, 1993).

Reports and Investigations

As soon as the mandated reporter has a reasonable suspicion of the possibility of neglect or abuse, reports are to be made to the CPS agency or to the local law enforcement agency. Such documentation of alleged abuse or neglect may be used in follow-up contact and for future court testimony, should such be necessary. The report should include the

- reporter's phone number, position, relationship to the child, and the school or agency phone number;
- child's name, address, and age;
- child's parents' names, address(es), and work places;
- names and ages of the child's siblings;
- description of suspected child abuse and neglect; documentation includes a precise description (size, color, shape, location, and number) of any injuries;
- child's statements;
- statements allegedly made by the child to others; and
- related circumstances and conditions in the home of which the reporter is aware.

The CPS agency investigates and establishes whether sufficient evidence exists to substantiate the report. In so doing, the CPS agency is required to follow the comprehensive standards established by the Wisconsin Department of Health and Family Services. The CPS agency must make a diligent effort to begin investigating the incident within 24 hours of the report. Its intake process is designed to gather and analyze information to make an initial assessment of the level of risk to the child's safety prior to completing a more thorough investigation (Wisconsin Department of Health and Social Services, 1994).

In addition, the CPS agency is required to inform the mandated reporter within 60 days of the report of action taken, if any, to protect the health and welfare of the child. Wisconsin requires the CPS agency to share only general information with the mandated reporter, not details such as therapy referrals, results of court action, transfers of custody, or reasons for any decision.

Beyond the School

Responding to suspected or actual abuse or neglect is a multi-agency process that frequently involves social services, law enforcement, health providers, and mental health services. This makes it incumbent upon the school nurse and staff members to understand how the social service and court systems work. Berkan and Kadushin's guide (WDPI, 1993) includes an excellent description of the purpose and process of the CPS system in Wisconsin.

The *Educator's Handbook on Child Abuse* (Sheboygan Area School District, 1990) and the *Orientation Manual* (National Association of School Nurses, 1995) offer a number of tips for those working with victims of abuse or neglect. Both during and after the investigation (which must be completed within 60 days of the report), the school nurse and other school staff members should be prepared to

- be aware of their own feelings about child abuse and neglect;
- be available to support the child;
- treat the child with respect and dignity;
- tailor experiences for student success;
- avoid negative remarks about the child's parents, caretakers, or the perpetrator of the abuse or neglect;
- avoid allowing personal frustration or anger at the perpetrator to negatively affect their attitude toward or treatment of the child;
- discuss the problem and causes of abuse and neglect with the child; and
- be alert for signs of continued abuse or neglect.

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Health Appraisals 7

Introduction

Appraisals of the health of school-age children and youth is a traditional aspect of the role of the school nurse. The value of this work is perhaps best illustrated by remembering the role nurses played in schools in the early 1900s, when the prevalence of highly-contagious diseases, fevers, rashes, and lice demanded nearly daily inspections of students by the nurse (Wold, 1981).

Although contagious disease is no longer the highest program priority, the school nurse continues to play an integral role in identifying childhood health-related problems. Occasionally, fevers, rashes, and lice still demand attention, as do a wide range of new health-related conditions and concerns. Similarly, the nurses role in identifying, recommending, and, in some cases, providing follow-up care has grown, as has the nurse's role in educating individual students.

Not all services offered by the school nurse are or should be reactive. For example, school nurses conduct health appraisals to detect previously unrecognized conditions or pre-clinical illnesses. That proactive approach facilitates early intervention and remediation while also limiting the potential for disabilities and adverse academic achievement due to a declining health status. The school nurse can also use the results of such appraisals, screening tests, and physical examinations to make decisions regarding the provision of direct services or referrals to appropriate community-based care providers.

To become competent at developing and implementing effective school-based health appraisal programs, nurses and key district staff members should do the following:

- Review state laws and regulations that require screening of students for specific health conditions.
- Review best-practice standards, and obtain necessary manuals and/or training (if required) to enhance knowledge of and skills in conducting specific health appraisals.
- In cooperation with district administrators and the local health advisory committee, review and revise, as necessary, district policies, procedures, and forms to reflect best-practice guidelines and principles of health appraisal programs.
- Prepare school staff, students, parents, and volunteers for the appraisal/screening process and practices.
- Provide training and ongoing monitoring of nonprofessional school health personnel and/or volunteers participating in health appraisals.
- Annually establish health appraisal programs based on state and other organization/agency guidelines, the documented health needs of the population served, and the value the appraisal provides commensurate to the resources required/allocated for its implementation.

To assist school nurses and staff members in effectively screening and following up on such efforts, this chapter will focus on:

- legal considerations,
- the role of the school nurse, and
- common health appraisals.

Legal Considerations

Federal and state laws provide few universal directives for specific health appraisals. However, initiatives and statutes do exist that reflect a belief that health appraisals are an appropriate and important component of school health services.

Federal Initiatives and Programs

The federal government has focused on the needs of children with developmental delays and health concerns for the past 30 years. Recently, the U.S. Department of Education's "Goals 2000" initiative and the U.S. Department of Health and Human Services' "Healthy People 2000" initiative have emphasized the need for early identification of health problems in children. Furthermore, IDEA-R97 requires identification of children with disabilities who may need special education and related services (34 CFR 300.532). Additionally, the federal Head Start program performance standards require programs to provide screening services in hearing, vision, growth, and other health parameters within 45 days of a child's admission into the program (45 CFR 1308.6).

State Laws and Initiatives

Wisconsin special education law (Wis. Stat. 115.77 (1)) requires local school boards to assess each child in the district who has yet to graduate from high school to "determine if there is reasonable cause to believe that the child is a child with a disability who may have special educational needs."

In addition, the Wisconsin Health Check (WHC) program—a preventive health program for Medical Assistance recipients under the age of 21—provides health and developmental histories, physical examinations, comprehensive and age-specific health screenings, and necessary services. The WHC screening protocol, which is outlined in the *Wisconsin Medicaid Provider Handbook*, is a highly regarded practice schedule which could serve school nurses and staff members well.

Role of the School Nurse

Because school is a place in which children spend an extended amount of time each year engaging in a wide variety of academic, recreational, and relational activities, it lends itself to early identification of and follow-up on health problems through carefully developed health assessment programs.

An effective health-appraisal program, including health histories, selected screenings, and planned follow-ups, will evolve from the understanding that community suitability and outcome accountability are essential for efficiency and effectiveness. In best-practice situations, a school health advisory committee regularly assesses a district's health-service policy about appraisals. This helps ensure that the policy and corresponding procedures reflect state guidelines and population health needs, and that each appraisal provides a value commensurate with the resources allocated for its implementation.

Most experts agree that children benefit from health supervision offered over time in a health-care "home base." *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents* (Green, 1994) contends that increased integration and coordination of services from various community resources, including the schools, is required to enhance adequate care for children without such a "home base."

Health appraisals are but one tool to help school nurses be more effective in providing such long-term care. To assist school nurses in providing such care where it is otherwise absent, *Bright Futures* offers:

- guidelines and schedules for health-supervision visits of children judged *not* to be at undue risk,
- trigger questions to support a health-supervision interview, and
- screening procedures which enhance basic health-supervision visits.

Because of the potential to make positive changes in the school environment by identifying student health needs and then modifying or removing barriers to students achieving their health and academic potential, the school nurse should be adept at using program-management skills in planning, developing, and evaluating the health-appraisal component of school health services.

Cross (1985) contends that failure to address program organization and administration (1) decreases the efficiency and efficacy of screening programs in communities with inadequate health resources and (2) causes unnecessary duplication of primary health-care services in wealthier school districts. A poorly designed appraisal program may exact both financial and developmental costs from the district and the students it serves.

While school nurses will want to work closely with staff members and administrators in developing an effective program for their own student population, the screening-program flowchart (Appendix P) developed by Donna Zaiger (1994) offers a model health-appraisal process. The Zaiger model, among others, offers a solid foundation upon which a district may build its own model.

In addition, Philip Nader (AAP, 1993), Jack Frye-Osier (WDPI, 1993), and Zaiger describe basic screening principles and procedures for specific health conditions. Typically, experts choose to focus on school-based appraisals of such health conditions based on

- frequency of occurrence,
- severity of occurrence,
- availability of beneficial treatment, and
- accessibility of appropriate target populations for early detection and intervention.

As with any proposed appraisal program, the ease and cost of administration and the acceptability of the procedures should be carefully considered in determining the overall benefit of conducting specific health appraisals.

Understandably, once a district establishes a health-appraisal program, the nurse will need to obtain necessary administration manuals, testing materials, and reporting forms. The nurse may also be responsible for

- identifying and recruiting people—including parents, senior citizens, secondary school students with an interest in health careers or service opportunities, and/or health-care professionals—to competently conduct screening procedures;
- developing and/or leading training programs for screening personnel;
- educating administrators, teachers, and parents regarding the purpose and value of the screening;
- preparing students and staff for actual screening and follow-up processes; and
- collecting structure, process, and outcome data to evaluate the effectiveness of the health-appraisal program.

Screening personnel must provide efficient and accurate implementation of screening protocols. This requires a basic understanding of the tools being used. Screeners should also be familiar with or trained to recognize age- or development-appropriate responses, particularly from preschoolers and other students who may be distracted during the assessment, and be able to quickly incorporate appropriate cueing alternatives in order to complete the appraisal.

Attentive, effective screening personnel are an essential program component for two reasons:

- Any failure to accurately identify a health problem will delay treatment.
- Referrals for inappropriate or excessive follow-up services may result in unnecessary stress and expense to the student and family.

The expertise and judgment of the school nurse is necessary to complete the follow-up and evaluation components of each appraisal program. For example, should a child not pass the initial screening conducted by a volunteer, the school nurse will need to rescreen the child and determine whether the initial results were accurate or whether they may have been skewed by situational factors during the screening.

Throughout the process, the school nurse is responsible for compiling and maintaining accurate records of the findings, referrals, and other follow-up activities. (See Chapter 11 for a discussion of school record systems and confidentiality.) In most cases, district policies and procedures will establish secondary activities as well as criteria for treatment and referral based on current standards. Should such policies and procedures not exist, the school nurse should play an integral role in developing them in cooperation with the school health advisory committee, other school staff members, and/or administrators.

Common Appraisals

Health History

A focused health history is an essential first step whenever the school nurse implements health appraisals, physical examinations, or selected screening programs. In many districts, focused health history questionnaires are commonly used to gather an initial database when a child begins school. Such histories offer school nurses a perspective on a variety of developmental factors, including:

- perinatal, developmental, and immunization histories
- illnesses, injuries, surgeries, and hospitalizations
- allergies
- medications
- daily self-care patterns, including nutritional intake, elimination, sleep, recreation, and other activities
- psychological considerations
- other family information, including extended health history, access to and use of a primary health-care provider, family dynamics, current priorities, and living arrangements

Although best practice endorses the right of each child to have a complete health history appraisal, the district may need to obtain more comprehensive data for those students with known health or learning impairments. Such information will help the district develop more effective individualized health-care and education plans.

The "School-Age Child Health Concerns Inventory" (MacBriar, et al., 1995) is one tool which may assist the school nurse in obtaining, with the child's participation, current information regarding health concerns. The inventory may also help nurses facilitate appropriate health education, counseling, treatment, or referral for follow-up care (see Appendix Q).

The health history becomes part of a student's health record and may be updated according to school district policy. Updates on changes in a child's health status or health-care experiences can be obtained through parental and student questionnaires elicited according to an identified schedule.

Physical Examinations

A periodic physical examination is important for all children and adolescents. Its objectives are to identify and follow-up on health conditions that may adversely affect the student's health, well-being, and ability to learn.

When physical examinations are conducted in the school setting, it is essential that efforts be made to ensure parental permission and that the privacy and confidentiality needs of the child are met.

While parents have primary responsibility for their children's health, the school district is responsible for the safety and well-being of students while they are in the school setting. Information concerning a child's past health experience assists school personnel to understand the child's present health status and conditions that may adversely affect the child's ability to learn.

Currently, physical examinations are not commonly conducted by school health personnel in the school setting. While each school district has the discretion to determine the necessity of a physical examination, sports physicals are required every other year for students wishing to participate in interscholastic athletics. The Wisconsin Interscholastic Athletic Association (WIAA) provides further guidance on athletic physical examinations. (Note: Physical examinations taken after April 1 are valid for the following two school years; those taken before April 1 are valid only for the remainder of the current school year and for the following school year.) As primary-care providers, nurse practitioners may legally sign athletic physical examination cards for both regional and state interscholastic athletic competitions.

The Wisconsin Health Check program is the means by which the state carries out the requirements of the federal Early and Periodic Screening, Diagnosis and Treatment Program that offers child-care and health-screening services to Medical Assistance-eligible children from birth to 21 years of age. WHC is based on a preventive health philosophy of detection and treatment of health problems before they become chronic or disabling and, ultimately, more costly to treat in terms of human and financial resources. The program provides early identification, diagnosis, and treatment of physical, emotional, or developmental problems.

In order to ensure periodic assessment of children, school districts should

- be aware of area Health Check programs,
- refer students who have not yet had a physical exam and have no medical provider, and
- contract with the local public health department to provide physical examinations if it is determined that the school setting provides a needed access point for children and their families.

Information and technical assistance about Health Check policy, clinical service components, certification, and billing is available from the Bureau for Wisconsin Division of Health, Bureau of Health-Care Financing, Health Check Program.

Developmental Screening

In schools, developmental screening tests are typically administered by education professionals. However, the school nurse plays an important role in collaborating with staff members assessing a student's health and developmental status. For example, the nurse may share insights and observations regarding the age-appropriate behavioral competencies demonstrated or absent during structured and nonstructured interactions with the child, a review of health and developmental history, current health-status data, and health practices. Through an analysis of assessment findings, the school nurse identifies actual or potential health or developmental problems and the relationship of those problems to the child's ability to learn.

Blood Pressure Assessment

Elevated blood pressure increases the risk for the development of hypertension or cardiovascular morbidity during one's lifetime. Prevention of hypertension in childhood and adolescence could extend the years of healthy life for many Americans. Proper diet, regular exercise, and abstinence from smoking help prevent high blood pressure.

While there is no specific legal requirement to provide blood pressure screening, blood pressure readings offer a physiological indicator of cardiovascular status. Elevated blood pressure is a risk factor for the development of hypertension and cardiovascular morbidity—if not during childhood, then during adulthood (see Appendix R, "Blood Pressure Screening Procedure").

Blood pressure measurement should not be considered an isolated procedure, but should be included in the physical assessment and continuing care of students. (See Appendixes S, T, U, and V for more information on normal blood pressure levels for girls and boys.) As always, trained personnel should follow standard practices for blood pressure measurement, equipment, referral, and follow-up (see Appendix W, "Blood Pressure Screening Referral").

Height and Weight Screening

While no legal requirement to provide height and weight screening exists, height and weight measurement is commonly done in elementary physical education, general health, and science classes and should be included in the physical assessment and continuing care and education of a child.

As with developmental screening, height and weight screening should not be viewed as an isolated screening procedure. Trained health personnel should follow standard practices for height and weight measurement, assessment, referral, and follow-up.

Height and weight measurements provide a simple and effective method of detecting growth abnormalities. These may indicate other health problems, including:

- systemic disorders, such as malnutrition and intestinal conditions;
- psychosocial conditions;
- congenital disorders, such as Turner's Syndrome; and
- conditions of the endocrine system, such as hypothyroidism and growth hormone deficiency.

The range of normal height and weight varies for each child, though general growth remains relatively constant. After rapid growth in the first two years of life, growth generally slows to two to two-and-one-half inches per year until puberty (approximately ages 11-13 years). Growth dramatically increases during puberty and lasts about two years (or until sexual development is achieved),when a child's growth is nearly completed. Growth patterns should follow normal growth curves of students of the same age and sex and fall between the fifth and 95th percentile curves on the standard growth chart.

Personnel

The school nurse should be responsible for overseeing height and weight screenings, though the task may properly be designated to trained, nonprofessional school health personnel or volunteers.

Standards

To be useful, measurements should be both accurate and plotted on standardized National Center for Health Statistics gender-specific growth charts (see Appendixes X, Y, Z, AA, BB, and CC for sample growth charts.) Height and weight are plotted against age and compared with standardized percentiles and previous measurements.

Equipment

Equipment should include a balance beam scale with nondetachable weights and a nonstretchable measuring tape attached to a vertical, flat surface, such as a wall. A right-angle head board is also needed for lowering onto the child's head when taking the measurement.

Procedures

Proper measuring techniques and a well-calibrated balance beam scale are essential. This includes proper positioning of the child on the scale when measuring weight and against the measuring tape when determining height. It is advisable to have one person responsible for taking height and weight measurements, as those taken by different individuals may vary (see Appendix DD, "Height and Weight Screening Procedure"). Measurements should be repeated to ensure reliability.

Growth should be charted on a standard growth chart so it can be meaningfully interpreted by health-care providers. It is important to note if a child's growth pattern makes a major shift from one growth curve to another. For example, a child whose growth pattern drops from the 80th percentile to the 50th percentile may have acquired an unknown health condition which needs investigating. Conversely, a child whose growth pattern remains at the 50th percentile over an extended period of time offers little or no cause for concern.

It is preferable to provide privacy when weighing and measuring individuals to reduce embarrassment and/or ridicule. Also, this offers an opportunity for identifying other health concerns and for brief one-to-one health counseling about nutrition, exercise, and other health-promotion strategies.

Referral and Follow-up

The school nurse is in an ideal position to ensure the early identification of students at risk for growth problems by providing appropriate assessments and referrals. Students should be referred for further assessment when

- weight for height or for age is above the 95th percentile;
- weight for height, weight for age, or height for age is below the fifth percentile; or
- a student's growth pattern changes dramatically.

Recordkeeping and Documentation

The growth chart should be a part of the student's patient health-care record maintained by the school. In addition, the summary results should be recorded on the student's physical health record, including any indication of referral and follow-up.

Hearing Screening

Hearing loss early in life will have profound consequences in a child's development, as hearing impairment may pose a significant barrier to

- development of speech and language skills,
- academic progress, and
- social and emotional development.

Hearing screening identifies students who have a conductive or sensorineural hearing loss in one or both ears; they can then be referred for a professional examination. Identification should ensure timely diagnosis and remediation/treatment in order to eliminate or lessen the negative effects of a previously undetected hearing problem.

The effects of a hearing loss are variable, depending on the nature and degree of loss as well as the appropriateness of the interventions. Any hearing loss may have a negative effect on a child's ability to communicate effectively and achieve academically. Undetected/unmanaged hearing loss may result in

- delayed speech and language skills;
- language deficits, which may lead to learning problems and limited academic achievement;
- difficulties in communication, which may lead to social isolation and a poor self-concept that can result in behavioral problems; and/or
- a negative impact on a child's vocational and educational choices.

Hearing Screening Requirements

Hearing screening should be included in any regular physical assessment, in continuing care (when appropriate), and when assessing whether a child has a disability which require(s) modifications and\or related services to facilitate involvement in a regular education program or through a special education program.

Wisconsin special education law (Wis. Stat. 115, Subchapter V, and Wis. Admin. Code PI 11) states that each school board is required to identify and evaluate all students with disabilities who may need special education and related services. This includes children under three years of age and children who have not graduated from high school who reside in the school district or in a state or county residential facility located in the school district. While these rules do not require specific screening procedures for individual disabilities, the intent to identify disabilities in children of all ages is clear.

In addition, Wis. Admin. Code PI 11 requires school districts to evaluate all students referred for suspicion of exceptional education need. (For more information on providing services to students with special health needs, see Chapter 10.)

Personnel

While screening for hearing loss in toddlers and children in high-priority designated populations may be difficult, a firm commitment to building a well-trained, supervised, and experienced team of screening personnel can make such a screening effort successful.

The program coordinator (commonly a school or public health nurse) is responsible for all aspects of a hearing screening program. The nurse should coordinate efforts with a local licensed audiologist, if available, to ensure that all program criteria are met and to ensure a quality screening program. If the district needs help in locating an audiologist in or near the school district, the nurse should contact the district medical advisor or the local public health department. The extent of the audiologist's involvement will vary with the population being screened, the skills and experience of others in the program, and the degree of community collaboration and consensus in the screening process.

The screener is the most important component of the hearing screening program; screening should not be conducted without well-trained, experienced, and supervised screening personnel. The *Wisconsin Guide to Childhood Hearing Screening* (WDPI, 1993, pp. 15-16) details training considerations. The screener's primary responsibility is to efficiently and accurately screen children using current recommended measures for designated grades and priority populations. This requires a basic understanding of the screening tools, the methods for applying the tools, normal and abnormal auditory mechanisms, and the impact of hearing loss on communication and learning.

Standards

Screening should occur at levels of 20 dB HL for the 1000 and 2000 Hz signals, and at 25 dB HL for the 4000 Hz signal (American National Standards Institute, 1989). An additional test signal should be added to the rescreening session. During the rescreening session, screening at 20 dB HL for the 3000 Hz signal (ANSI, 1989) should also occur in the ear(s) in which the child passes the screening at all frequencies except 4000 Hz.

Current best practices for identifying hearing disabilities in infants, toddlers, early childhood, and school-age children and youth can be found in the *Wisconsin Guide to Childhood Hearing Screening* (WDPI, 1993, p. 16).

Equipment

Hearing screenings rely on three specific pieces of equipment.

- **Pure-tone audiometers** generate single-frequency tones at varying hearing levels for the purposes of testing hearing acuity and screening for hearing loss. Pure-tone audiometric screening can be successfully conducted with children who are functioning at a developmental age of at least three years. Audiometers used for pure-tone screening must meet ANSI S3.6-1989 specifications and should be calibrated annually to those specifications.
- **Tympanometers** identify abnormalities of the middle ear and are frequently used in hearing screening programs for specific populations of school-age children. Tympanometers measure compliance changes in the middle ear as air pressure is varied in the ear canal. Tympanometer specifications must be in accordance with the ANSI standard on aural acoustic imminence instruments (ANSI, 1988) and must reliably and clearly provide
  - a plot of changes in the compliance of the middle ear system as pressure in the ear canal is continually varied from positive to negative values (tympanogram);
  - quantification of the compliance value measured at the most compliant point on the tympanogram,
  - quantification of the equivalent ear canal volume, and
  - quantification of the ear canal pressure value corresponding to the most compliant point on the tympanogram.

Currently, no national standard for the calibration of tympanometers exists. Tympanometers may, however, be calibrated to the equipment manufacturer's specifications.

- **Otoscopic** examination prior to administering hearing screening tests can facilitate prompt referrals for active ear disease and/or medically significant ear canal and ear drum abnormalities. It can also reveal the presence of excessive amounts of cerumen (ear wax), which is a common cause of hearing screening failure in children.

Visualizing, examining, and detecting abnormalities of the ear canal and ear drum require training and experience. Because such testing is often difficult with young children, the decision to include otoscopy should be made in consultation with an audiologist or health-care provider (physician, nurse practitioner, or physician's assistant) experienced in otoscopic examinations of the target population.

Procedures

The onset of most significant hearing loss and disease processes that lead to some common childhood hearing losses occurs well before children enter kindergarten. If an annual hearing screening was conducted for all children ages birth to five years, screening in grades K-12 could be restricted to

- students known to have recurrent or chronic ear disease;

- students with other medical conditions known to be associated with hearing loss;
- students referred by teachers, parents, or others because of suspeced hearing loss, and
- students known to be at risk for noise-induced hearing loss, including those who regularly engage in very noisy leisure/recreational activities, those enrolled in vocational training programs, and those engaged in employment activities involving loud equipment.

Referral and Follow-up

When a child fails a hearing screening, the process of facilitating prompt medical evaluation should begin (see Appendixes EE and FF for hearing screening test instructions). When working with parents, the school nurse or health program personnel should

- promptly notify them of the test results;
- explain the screening process;
- emphasize that the screening results are not diagnostic but advisory and suggest the possible presence of a hearing loss;
- explain the need for prompt medical and hearing evaluations which document any hearing loss and provide a diagnosis;
- explain that there are potentially negative developmental consequences for a child when hearing loss is ignored;
- assist families in locating evaluation and treatment services and financial assistance, if necessary and available; and
- follow-up to determine if evaluation occurred and whether ongoing treatment is necessary.

Parental education about the screening process and the causes, consequences, and treatment of childhood hearing impairment is important. Program personnel may find it beneficial to use commercially available brochures, pamphlets, and other publications.

When working with health-care providers, the school nurse should (1) provide complete screening information, including the screening tests used and dates of the failures, and (2) request feedback about the evaluation results.

Recordkeeping and Documentation

Hearing screening results should be a part of each student's school health record. The summary results should be recorded on the student's physical health record, including any indication of referral and follow-up. (See Appendix GG, "Sample Parent Notification Letter for Hearing Screening," and Appendix HH, "Hearing Screening Referral/Medical Evaluation.")

Role of the Classroom Teacher

Classroom teachers have the opportunity to observe students daily over an extended period of time. Consequently, teachers may, with the exception of the student's parent(s)/guardian(s), be in the best position to detect any early signs of unusual reactions, conditions, or behavior changes that may signal a hearing problem. Hearing problems may be detected by a teacher when a student

- does not respond to normal speech,
- favors one ear (indicated by turning one ear to the speaker),
- speaks too loudly or too softly,
- strains to hear the speaker,
- shows facial evidence of intense concentration,
- is inattentive in oral activities,
- frequently asks to have words or statements repeated,
- mispronounces common words,
- makes frequent or unusual mistakes in following directions,
- regresses academically following a serious illness, and/or
- is not reaching his or her academic potential.

Resources

Readers may wish to contact any number of organizations for additional information on hearing screening. (More complete information about the following organizations is contained in Chapter 13, "Resources.")

- Alexander Graham Bell Association for the Deaf
- American Speech-Language-Hearing Association
- Channing L. Bete Company
- Minnesota Foundation for Better Hearing and Speech
- National Association for Hearing and Speech Action
- National Information Center on Deafness
- Wisconsin School for the Deaf

Vision Screening

Most significant visual abnormalities develop before or around the time of school entry. These include strabismus, hyperopia, and amblyopia. While most of these visual problems should be detected well before kindergarten, some may develop during the first two years of school.

School-based vision screening helps identify those students who may have a vision impairment that may prevent them from benefiting from their educational program; it also facilitates their referral for a professional eye examination.

The most common visual abnormality that develops during the school years is myopia. Binocular myopia of 20\70 or worse rises in prevalence from one percent in six-year-olds to 20 percent at age 16 (Peckham et al., 1977).

Visual screening for strabismus, hyperopia, and amblyopia should be done just prior to or early in kindergarten. Further testing late in the first grade could reveal vision problems that developed during the first two years of school.

In its *Guidelines for Health Supervision II* (1987), the American Academy of Pediatrics (AAP) recommends that visual acuity be regularly screened as a part of routine physical assessments on school-age children. In addition, the AAP recommends that children be tested for strabismus at five years of age.

Vision Screening Requirements

Vision screening should be included in any regular physical assessment, in continuing care (when appropriate), and when assessing whether a child has exceptional educational needs or a disability requiring modifications and/or related services to succeed in a regular education program.

Wis. Stat. 115, Subchapter V, and Wis. Admin. Code PI 11 state that each school board is required to identify and evaluate all students with disabilities or exceptional education needs who need special education and related services; this includes children under three years of age and children who have not graduated from high school who reside in the school district or in a state or county residential facility located in the school district. While these rules do not require specific screening procedures for individual disabilities, the intent to identify disabilities in children of all ages is clear.

In addition, Wis. Admin. Code PI 11 requires school districts to evaluate all students referred for suspicion of exceptional education need. (For more information on providing services to students with special health needs, see Chapter 10.)

Personnel

The program coordinator (commonly the school or public health nurse) is responsible for overseeing the vision screening program. Vision screening may be delegated to properly trained, school health personnel or volunteers. Screening personnel are the most important component of the screening program. Without competent screening personnel, all other vision screening resources may be jeopardized for maximum results. Competence in vision screening requires the screener to have a basic understanding of the screening tools, the methods for applying the tools, normal and abnormal findings, and the implications of visual impairment on learning. After trained personnel conduct the initial screening, the school nurse should rescreen students who failed the initial screening and follow-up with information and referral for parents as indicated by results of the rescreening activities.

Standards

Information regarding each of the recommended screening or examination tools and corresponding pass/fail and referral criteria is available from Prevent Blindness—Wisconsin, screening tool manufacturers, clinical assessment literature, and local health- and eye-care providers.

While the Wisconsin Coalition for Children's Vision Screening (1997) developed a summary of program standards which exceeds current Prevent Blindness—Wisconsin recommendations (see Appendix II), both organizations recommend that parents seek professional eye care for their child prior to entering school (age four or five), periodically throughout their school years, and if the child is observed with one or more of the following conditions:

- rubs eyes excessively
- shuts or covers one eye
- tilts head or thrusts head forward
- has difficulty with reading, other close-up work, or seeing the chalk board
- crosses eyes
- says s/he cannot see well
- notes blurred or double vision
- has red-rimmed, encrusted, or swollen eyelids
- has inflamed or watery eyes
- has sties (infections) on eyelids
- suffers from itchy, burning, or scratchy eyes
- suffers from dizziness, headaches, or nausea following close-up work

Equipment

Both AAP and Prevent Blindness–Wisconsin recommend the

- HOTV or Lea Symbol Chart for children too young to cooperate with the Snellen E Chart.
- Snellen E chart for screening five and six year old children.
- Snellen 10- or 20-foot alphabet chart for screening children seven years of age or older.
- Random Dot E Stereopsis Tool for all age groups.

A number of vision screening tools are available from a variety of manufacturers of vision-testing equipment. It is important that all tools used during the screening be available well in advance to train screeners. To ensure valid screening results, it is important that all vision screening equipment be properly maintained according to manufacturer's instructions.

Procedures

Descriptions of the procedures for the two most common screening tools—the Snellen chart and the Random Dot E Stereopsis Tool—used in the school setting can be found in Appendixes JJ and KK.)

The nurse should notify parents of all children who do not perform satisfactorily on the vision screening and any subsequent retest. A referral means that there is sufficient deviation in the child's visual condition to warrant a more complete examination for diagnosis and treatment by a qualified eye-care specialist.

When a child fails the vision screening, the process of facilitating prompt evaluation by an eye-care specialist should begin. When working with parents, the school nurse or health program personnel should

- immediately notify them of the test results;
- explain the screening process;
- emphasize that the screening results are not diagnostic but advisory and suggest the presence of a possible vision impairment;
- explain the need for prompt evaluation by an eye-care specialist who can provide a diagnosis and document any vision impairment;
- explain that there are potentially negative developmental consequences for a child when vision impairment is ignored;
- assist families in locating evaluation and treatment services and financial assistance, if necessary and available; and
- follow-up to determine if evaluation occurred and whether ongoing treatment is necessary.

Parental education about the screening process and the causes, consequences, and treatment of childhood vision problems is important. School health personnel may find it easier to use commercially available brochures, pamphlets, and other publications.

When working with health-care providers, the school nurse should

- provide complete screening information, including the screening tests used and dates of the failures; and
- request feedback about the evaluation results.

It is important to note that an eye-care specialist, such as an optometrist or ophthalmologist, may recommend appropriate educational adjustments or modifications to be carried out by school personnel.

Recordkeeping and Documentation

All vision screening results—passes and failures, referrals, and follow-ups—should be recorded on the student's school health record. If a referral confirms a vision problem, the student's physical health record should indicate the nature of the abnormality as determined by the specialist and a summary of any treatment prescribed. (See Appendix LL, "Sample Parent Notification Letter and Vision Screening Referral/Examiner's Report.")

Role of the Classroom Teacher

Classroom teachers have the opportunity to observe students daily over an extended period of time. Consequently, teachers may, with the exception of the student's parent(s)/guardian(s), be in the best position to detect any early signs of a possible vision problem. When a teacher sees any of the signs noted earlier in the vision screening section of this chapter, the student should be referred to the school nurse. If the teacher and/or nurse detect a vision problem that significantly influences the child's ability to learn, the student should be referred to the district special education director and/or teachers of the visually impaired in the local district or cooperative educational service agency (CESA) to discuss possible classroom modifications or potential EEN referral.

Resources

Readers may wish to contact any number of organizations for additional information on vision screening. (More information about the following organizations is contained in Chapter 12, "Resources.")

- Prevent Blindness–Wisconsin
- Wisconsin Coalition for Children's Vision Screening

- Wisconsin Council for the Blind
- Wisconsin School for the Visually Handicapped.

Dental Screening

While dental screening is designed to detect early dental and oral health problems in children, it does not replace the need for regular dental examinations in a dentist's office. In fact, dental screening provides an ideal opportunity for school nurses to emphasize the prevention of dental diseases, enhance the promotion of good dental self-care, and help build a positive attitude in children who have not received prior dental care. It also provides baseline information so that periodic evaluations and, if necessary, referrals may be made.

While Wisconsin does not require that children entering school have a dental examination, it is highly recommended that children undergo a dental screening or, preferably, a dental examination before entering school. Districts may wish to recommend a dental examination along with vision and physical examinations for children entering school.

Personnel

The nurse may wish to consult with the chief dental officer in the Bureau of Public Health during early planning phases. The nurse should coordinate efforts with a local dentist, if available, to ensure that all program criteria are met and that a high-quality screening is conducted. A dental hygienist, dentist, or school nurse can perform a screening inspection with a mouth mirror and explorer or with a tongue blade and penlight.

Equipment

A mouth mirror is used to provide indirect vision; retract cheeks, lips, and tongue; and maintain clear vision. A useful technique is to hold the mirror in a pen grasp, rubbing along buccal mucosa (cheeks) to coat with saliva, or to ask the student to breathe through their nose to prevent condensation on the mirror.

A wet tongue depressor (to prevent adhesion to oral tissues), also held in a pen grip, is used to facilitate direct vision.

Additional equipment needed includes:

- disposable gloves
- masks for the prevention of Hepatitis B and other bloodborne pathogens
- cotton gauze
- penlight
- plastic bags for disposable nonreusable equipment used during the inspection
- hand-washing facilities

Procedure

The school nurse conducting the screening should review the child's

- dental-health history;
- date of last dental examination;
- dental habits, including brushing and flossing; and,
- snack habits.

The most feasible and simple type of screening in the school setting is an inspection using tongue blades and adequate lighting/illumination. This procedure is recommended by the American Dental Association and includes systematic inspection of the

- face and neck for lesions or swollen glands;
- mucous membranes (lips, tongue, soft and hard palates, tonsils, and cheeks) for redness, exudate, swelling, blisters, and growths; and
- teeth and gums for age-appropriate dentition, evidence of dental caries, broken or chipped teeth, gross malocclusion, infection or swelling, bleeding and inflammation, changes in color, texture and position of gum tissue, poor oral hygiene, and mouth odor.

This approach helps the school nurse identify dental problems that warrant a student referral to a dentist for proper care. A complete dental examination with x-rays are most appropriately carried out in a licensed dental office.

In addition, the school-based screening provides, during the examination, an opportunity for the nurse to offer the student dental health education which emphasizes

- importance of healthy tooth development,
- prevention of tooth decay,
- importance of preventive dental care,
- role of diet and fluoride in dental health,
- tooth brushing and flossing procedures, and
- protection from dental injury.

Referral and Follow-up

When a school screening has revealed a dental problem, the school nurse should refer the child for a complete dental examination by a licensed dentist.

Follow-up by the school nurse is important to help families overcome barriers they may face in obtaining dental care. As a liaison between families and dental-care professionals, the school nurse may be aware of dentists who accept Medicaid or who will provide dental services on a sliding-fee scale for families in need of such financial considerations.

Recordkeeping and Documentation

Results of the dental screening should be recorded on the student's school health record. In addition, the summary results of referral, examinations, and treatment should be recorded on the child's physical health record. The school nurse should also inform the child's teacher of any dental or other oral problems that may affect the child's ability to participate in the classroom or other school activities.

Role of the Classroom Teacher

Teachers play an important role in the promotion of a child's oral health by being aware of children who have tooth pain or have speech defects that may be attributed to missing teeth. Teachers can reinforce the importance of daily brushing and other oral hygiene practices.

In addition, because teachers see students on a daily basis, the teacher may observe behavior that may cause dental or speech problems, such as finger sucking and nail biting.

The teacher may also be able to make allowances for children who, for example, need more time to eat lunch because of an oral infection or missing teeth.

Postural and Scoliosis Screening

Adolescent idiopathic scoliosis is a medical term for a lateral or S-shaped curvature of the spine that may occur in the cervicothoracic, thoracic, or thoracolumbar regions. Scoliosis affects school-age children during their rapid growth years, usually around the ages of 10-12.

While precise prevalence figures for scoliosis are not available, estimates suggest that approximately five percent of children are affected— girls nearly eight times as often as boys (Sells and May, 1974; Hill and Romm, 1977).

While there is no legal requirement to provide postural or scoliosis screening in Wisconsin schools, it should be included in any regular physical assessment and continuing care, when appropriate.

Postural screening may detect early signs of spinal problems that warrant further medical evaluation. However, according to the U.S. Preventive Services Task Force (USPSTF, 1993), there is insufficient evidence from clinical research that routine scoliosis screening is effective in changing the outcome of adolescent idiopathic scoliosis. Although the task force does not take formal positions on preventive practices outside clinicians' offices, the panel did reveal that it found little scientific reason to distinguish between school-based and office-based screening for scoliosis. On the other hand, limitations in the design of existing studies also make it difficult to conclude that scoliosis screening is ineffective.

If screening for scoliosis is effective, discontinuation of school screening may have a disproportionate impact on students from minority or low-income families. Often, they have less access to a primary-care provider than students whose financial status provides opportunities outside of the school setting to obtain back examinations. For such disadvantaged students, school-based screening may provide the only opportunity for back inspections (USPSTF, 1993).

The American Academy of Orthopaedic Surgeons, in a 1987 position statement, recommend the following minimum screenings:

- Girls should be screened twice (in grades five and seven).
- Boys should be screened once (in grade eight or nine).

Other related organizations offer the following recommendations:

- The Scoliosis Research Society calls for annual screenings of all children from 10 to 14 years of age.
- The American Academy of Pediatrics recommends scoliosis screenings at routine health-supervision visits when students reach 10, 12, 14, and 16 years of age.

Personnel

The school nurse responsible for implementing and supervising the postural and scoliosis screening program should consult with the school administrator, the health advisory committee, the medical advisor, and others, as appropriate, to discuss the screening program's importance, implementation, and connections with the entire school health program and health services provided in the community.

Screening personnel may include trained, nonprofessional health persons under the supervision of the school nurse or medical advisor. Competent postural and scoliosis screeners have a basic understanding of

- screening tools;
- methods for applying the tools;
- normal and abnormal findings, and
- implications of a spinal deformity on the child's ability to participate in his or her own learning.

After trained personnel conduct the initial screening, the school nurse should rescreen students who failed the initial screening. Screeners should also take part in annual update training.

Procedure

The screening program has two components: an initial educational session with students and the screening.

In the educational session, screening personnel will inform students

- how, when, and where the screening will be done;
- what the screener will be looking for;
- about special clothes to be worn during the screening (female students are asked to bring a two-piece swimsuit or halter top and shorts);
- about postural problems; and
- about the distribution of an initial letter to parents (see Appendix MM).

A schedule for screening should be prepared and coordinated in advance with classroom teachers whose students will take part in the screening.

The clinical examination method for scoliosis (see Appendix NN) includes the following steps:

- The student bends forward at a right angle (90 degrees) at the hips. The child's legs must be fully extended at the knees, the arms dangling with palms facing, and with the feet preferably bare.
- The screener examines horizontally down the entire spine, from behind, for paravertebral asymmetry in the thoracic spine. This can be determined by placing a straight edge across the rib deformity, horizontal to the floor, placing a ruler vertically on the concave side, and measuring the height of the asymmetry. Asymmetry greater than 8mm is considered abnormal. If the screener is using a scoliometer placed across the rib hump, eight to 10 degrees of inclination are considered justification for referral. (Prior consultation with the school health advisory committee and/or medical advisor will determine local referral criteria.)
- Children who have positive findings during the initial screening should be rescreened later that day or another day to determine if the findings were true positive findings and not related to other factors.

Referral and Follow-up

Following rescreening to determine if there is sufficient deviation to warrant a more complete examination by a student's primary-care provider, the school nurse should contact the parent(s)/guardian(s) of all children with positive findings to make a referral (see Appendix OO).

Parental education about the screening process and the causes, consequences, and treatment of postural problems and scoliosis is important. School health personnel may find it beneficial to use commercially available brochures, pamphlets, and other publications.

When working with parents, program personnel should

- promptly notify them of the test results;
- explain the screening process;
- emphasize that the screening results are not diagnostic but advisory;
- explain the need for prompt evaluation by the student's physician to provide a diagnosis and document any spinal problem;
- explain that there are potentially negative developmental consequences for a child when possible spinal problems are ignored;
- assist families in locating evaluation and treatment services and financial assistance, if necessary and available; and
- follow-up to determine if evaluation occurred and whether ongoing treatment is necessary.

When a child shows early signs of possible spinal problems, the process of facilitating prompt evaluation by the child's physician should begin. It is vital that the nurse follow up with the student and parent(s)/guardian(s) to ensure that the suspected spinal problem has been diagnosed and treated by a competent specialist.

When working with health-care providers, the school nurse should:

- provide complete screening information including the dates of the screening and rescreening and the screening methods used; and
- request feedback about the evaluation results.

It is important for districts to note that a family physician or orthopedic specialist may recommend appropriate educational adjustments or modifications to be carried out by school personnel.

Recordkeeping and Documentation

All postural and scoliosis screening results—passes and failures—should be recorded on the student's school health record. If a referral confirms a spinal problem, the student's physical health record should indicate the screening results; the nature of the abnormality, as determined by the specialist; and a summary of any treatment prescribed.

Resources

Readers may wish to contact any number of organizations for additional information on scoliosis screening. (More information about the following organizations is contained in Chapter 13, "Resources.")

- National Scoliosis Foundation
- National Association of School Nurses

Summary

Population-based appraisals for health problems are an important component of a school health program designed to provide early intervention and remediation and to limit potential disability and negative effects on students' health status and academic achievement.

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Illness and Injury Care

8

Introduction

Nonemergency illness and injuries occur wherever children are present. Prompt management of such illnesses and injuries within the school setting will reduce absenteeism and positively affect cognitive performance and participation.

Developing policies and procedures for the management of illness and injury is the shared responsibility of the school board, school administrator, school nurse, and the medical advisor. Collaboration with community health-care providers, families, students, and community partners is essential. This collaboration must respect and incorporate ethnic, cultural, and spiritual health-care practices and beliefs of individuals and the community.

In order to be most effective in providing care to students and staff members with illnesses, injuries, and/or chronic diseases, school nurses and districts should strive to

- review state and federal laws and regulations as well as district policies and procedures regarding the provision of such care in the school setting.
- in cooperation with the school nurse, district administrator, medical advisor, and/or health committee, annually review and revise district policies, procedures, and forms to meet statutory requirements and standards of nursing practice in the school setting.
- learn about prevalent health conditions in the community by contacting local health departments and community health-care providers.
- evaluate and enhance professional knowledge and skills relating to the provision of care to those in the school setting with illnesses, injuries, and chronic diseases.
- evaluate and enhance personal communiciations skills to ensure that students, families, and staff members understand the health problems faced by those in the school community and the impact those problems may have on educational outcomes.
- enhance professional knowledge and skills by reading journals; consulting with other health-care professionals; identifying and studying community, regional, and/or national resources; and establishing enduring relationships with practicing colleagues and professional organizations.

To assist the school nurse and staff members in achieving those goals for the purpose of developing policies and procedures for caring for students with illnesses, injuries, and chronic diseases, this chapter addresses:

- legal considerations;
- roles and responsibilities;
- communicating the health-services plan;
- managing injuries and illnesses;
- acute and episodic health problems;
- chronic illnesses;
- other health conditions and concerns; and
- environmental safety.

Legal Considerations

As with any school district policy or procedure, those relating to management of students with illnesses and injuries must comply with all federal regulations, Wisconsin statutes, and administrative codes pertaining to school health-service programs. Such legislation mandates that districts adopt and implement policies and procedures that address specific provisions of the legislation.

Federal Regulations

A number of federal regulations address policies and procedures for management of student illness and injury, including:

- Individuals with Disabilities Education Act (IDEA) and its reauthorized version (IDEA-R97)—which are undergirded by Wis. Stat. 115 and PI 11—regulate school nursing. Together, they require school districts to provide the related nursing services necessary to ensure that individual children with disabilities benefit from special education programs.
- Section 504 of Vocational Rehabilitation Act of 1973 requires school districts to provide every qualified handicapped person in the school's jurisdiction with general education, special education, related aids, and services designed to meet individual educational needs.
- Americans With Disabilities Act (ADA)—42-USC, 12-116CFR, Part 1630—specifies that, as of January 26, 1992, public entities and public accommodations must ensure that individuals with disabilities have full access to and equal employment of all facilities, programs, goods, and services. ADA extends many of the rights/duties defined by Section 504 to public accommodations such as restaurants, hotels, theaters, stores, doctor's offices, museums, private schools, and child care. (See Chapter 10 of this publication for more specific information about these federal laws and their application in Wisconsin schools.)

Wisconsin Statutes

A number of Wisconsin statutes and administrative codes have an impact on policies and procedures for the management of student illness and injury:

- Wis. Stat. 101.55 and implementing Wis. Admin. Code DILHR 32.50 1910.1030–Bloodborne Pathogens Standard requires school districts to implement employee health and safety standards; Wis. Admin. Code ILHR 32.50 applies Occupational Health and Safety Administration standards (29 CFR 1910.1030) to minimize or eliminate occupational exposure to Hepatitis B, and human immunodeficiency virus (HIV), and other bloodborne pathogens and requires Hepatitis B vaccinations of specific school personnel.
- Wis. Stat. 118.24(2)(f)–Students with Problems Related to Alcohol and Drugs requires school administrators to ensure that principals and student services staff cooperate with county mental health and alcohol and other drug officials under Wis. Stat. 51.42 when disseminating information about the availability of alcohol and other drug services and to jointly establish procedures for referring students experiencing problems related to alcohol or other drug use to appropriate services.
- Wis. Stat. 118.29–Administration of Drugs to Students and Emergency Care offers guidance to district administrators and principals regarding the administration of oral medications and emergency care to students. (Medication administration is discussed in more detail in Chapter 5.)
- Wis. Stat. 121.02(1)(g)–Emergency Nursing Services requires each school board to provide emergency nursing services during all school-sponsored activities both on and off school premises; Wis. Admin. Code PI 8.01(g) outlines minimum standards when implementing emergency nursing services. (Emergency Nursing Services is discussed in more detail in Chapter 9.)
- Wis. Stat. 121.02(1)(i)–Safe and Healthful Facilities requires each school board to provide safe and healthful facilities, including compliance with ss. 254.11 to 254.178 Wis. Stats., relating to environmental health.
- Wis. Stat. 251–Required Services of Local Health Departments requires local health departments to provide basic public health services and ensure conditions in which the population can be healthy.
- Wis. Stat. 252–Communicable Disease requires school districts to ensure child immunizations and identify, report, and temporarily exclude children who may spread communicable diseases. (This state and corresponding Wis. Admin. Codes HSS 144 and 145 are discussed in more detail in Chapter 4.)
- Wis. Stat. 441–Nurse Practice Act defines the scope of practice for registered nurses and licensed practical nurses; Wis. Admin. Codes N6 and N7 identify standards of practice and rules of conduct for registered nurses and licensed practical nurses.

Roles and Responsibilities

Individuals who are responsible for management of common nonemergency illnesses and injuries include, but are not limited to

- school boards and administrators
- school principals

- registered professional nurses
- trained nonprofessional school health personnel
- parents or legal guardians
- students
- public health departments and officers

School Boards and Administrators

School boards and administrators are responsible for adopting policies and procedures, providing properly trained personnel, funding programs that address student health needs, and developing supportive services and information and management structures that inform and improve educational outcomes and the health status of students. Several national and related state organizations have formulated recommendations (see Figure 24) to aid schools boards and administrators in this endeavor, including the

- American Academy of Pediatrics (AAP)
- American School Health Association (ASHA)
- Association of State and Territorial Health Officials (ASTHO)
- Joint Task Force for the Management of Children with Special Health Needs
- National Association of School Nurses (NASN)
- National School Boards Association (NSBA)

School Principals

Within the framework of school district policies, principals have traditionally been granted the authority and responsibility for supervising and implementing policies relating to management of common illnesses and injuries within their respective schools.

Unfortunately, because principals are rarely trained health-care administrators, they often interpret the law as defining the totality of what is allowed in the provision of care rather than what is considered minimum requirements when providing school health services. Thus, the school nurse is a vital partner of the principal in fulfilling the educational mission of the school by attending to student health-care needs which might otherwise limit a student's participation in academic and extracurricular activities.

Registered Professional Nurses

The registered professional nurse usually directs the day-to-day management of school health services. In Standard 5 of its *Roles and Standards of School Nursing Practice* (1993), the National Association of School Nurses states that the registered professional nurse is accountable for establishing and maintaining a comprehensive school health-service program. Understandably, managing common illness and injury is a component of a comprehensive school health program.

The nurse's role when working with individual students is clearly defined by Standard I: Clinical Knowledge; Standard II: Nursing Process; and Standard III: Clients with Special Needs. These standards of nursing practice state that nurses

- assess students' health-care needs;
- analyze data to formulate nursing diagnoses;
- identify outcomes, plan, and implement care;
- evaluate the effectiveness of the care provided;
- document the care provided; and
- communicate with parent(s)/legal guardian(s) and school staff members.

Furthermore, the nurse should

- systematically evaluate the quality of care;
- maintain current knowledge of nursing practice;
- provide culturally competent care;
- frame care in an ethical manner;
- consider resource utilization;
- train, monitor, and supervise delegated nursing acts of nonprofessional school health personnel; and
- provide general education and training for school staff members and others.

Trained Nonprofessional School Health Personnel

Trained non-nursing personnel may include nursing assistants, aides, clerks, or volunteers who have been trained in accordance with school district policies and guidelines in direct relation to their job duties. The school district should define the allocation and roles of such personnel in accordance with the Nurse Practice Act and other pertinent state statutes. The registered nurse delegates nursing responsibilities to nonprofessional or assistive personnel, then appropriately trains, monitors, supervises, and evaluates each person's performance of the delegated tasks. (For more information, see Chapter 2, "School Nursing: Profession and Practice.")

Parents or Legal Guardians

In most cases, the parent or legal guardian will have the best knowledge of and information re-

Figure 24

National Organizations' Recommendations for School Health Programs

American Academy of Pediatrics

In their 1993 publication *School Health: Policy and Practice*, the AAP identifies and elaborates on goals and objectives for school health programs. AAP believes that school districts should use these goals and objectives when formulating health-related policies and procedures. Of the seven goals, five relate to illness and injury management:

- Goal I–Assure access to primary health-care.
- Goal II–Provide a system for dealing with crisis medical situations.
- Goal IV–Provide systems for identification and solution of students' health and educational problems.
- Goal VI–Provide a healthful and safe school environment that facilitates learning.
- Goal VII–Provide a system of evaluation of the effectiveness of the school health program.

American School Health Association

The American School Health Association views schools as a focal point for influencing student health. They recommend the development of comprehensive school health programs which include multidisciplinary teams of educators and service providers, worksite health-promotion programs for school personnel and integrated programming between schools and community agencies. School administrators and school staff may find ASHA materials useful as they formulate policies for school health services, education, school environment, food services, physical education, guidance and counseling, and school psychology.

Association of State and Territorial Health Officials

The Association of State and Territorial Health Officials was founded on the principle that school health programs provide unique opportunities to promote good health and prevent diseases and disabilities. The ASTHO identifies and elaborates on ways public health agencies can support school health programs through policy formulation, school health personnel training, providing technical assistance, collecting and reporting data on school health status, and providing direct nursing services to address acute and chronic student health needs.

Joint Task Force for the Management of Children with Special Health Needs

The Joint Task Force for the Management of Children with Special Health Needs is composed of representatives from five organizations:

- American Federation of Teachers
- Association of State and Territorial Health Officials
- The Council for Exceptional Children
- National Association of School Nurses
- National Education Association

The recommendations produced by this task force can be particularly helpful to nurses and school administrators when determining delineation of roles and responsibilities for safe delivery of care in the school setting. For children with special health-care needs, the document provides a matrix of common procedures. It also delineates the persons who are qualified to perform those procedures and when they are allowed to do so (as many of the procedures are regulated by professional standards of practice).

National Association of School Nurses

The National Association of School Nurses (NASN) publishes resolution and policy statements which promote the delivery of quality health programs and services in the school setting. It also provides numerous publications that identify and elaborate on a variety of school health goals, objectives, implementation methods, and evaluation strategies and that define the school nurse's role in each area.

School administrators and nurses may find NASN materials particularly helpful as they

- formulate district policies and procedures establishing and maintaining a school health program, and
- develop guidelines to address a variety of school health issues, including evaluation of school health personnel and working with students with disabilities.

National School Boards Association

The NSBA and Wisconsin Association of School Boards (WASB) recommend that school districts establish school health services that include appropriate school-based and referral services. These services should be designed to address problems that limit a student's ability to learn. The NSBA guidelines indicate that school districts are responsible for establishing policies, procedures, and evaluation criteria that comply with state and federal statutes and provide for the well-being of their students. These should

- clearly define the roles of school health personnel;
- collect school health data for the purpose identifying school district needs, allocating human and material resources, and evaluating programs; and
- budget for and allocate resources to maintain school health services that meet the needs of the district's students.

garding their child's health. Everyone benefits when families and school health personnel work cooperatively to meet the child's needs.

As the person ultimately responsible for the health of the student, parents and other legal guardians are responsible for complying with school district policies regarding health-related matters, such as those related to immunizations and physical examinations for participation on athletic teams. The parent or legal guardian must complete and annually update appropriate health records, such as the emergency medical information card, in accordance with district policy. The district must also acquire a parent's/guardian's permission before releasing the student's school health records. (For more information, see Chapter 11, "Administrative Issues.")

While most of the previously mentioned activities are preventive or proactive, parents/guardians are responsible for notifying the school when a child is suffering from a health problem and when voluntarily excluding their child from school if the child has a condition, such as chicken pox or head lice, that poses a public health threat or nuisance to others.

Parents and guardians have ultimate responsibility for and authority over decisions made relating to the welfare of their children. However, when those children enter school as students, it is understood that some of that responsibility is entrusted to the school district during the day.

To avoid confusion over what care is available, districts should develop and communicate in writing to families a policy and corresponding guidelines regarding managing common student illnesses and injuries during the school day and at all school-sponsored activities.

Similarly, districts should inform families about policies relating to the provision of uncommon (or emergency) care, whether the circumstances are life-threatening (such as major thoracic trauma or a heart attack) or are urgent but not life-threatening (such as a compound fracture or dislocation of an arm or leg).

It is important for nurses and district administrators to know that, when permission must be sought from a student's parent(s)/guardian(s), some legal guardians may not have the authority to approve such care. The appropriate school personnel—such as the principal, school record custodian, or school nurse, among others—needs to keep on file and review the legal documents that clarify the guardian's authority.

If the child has a chronic condition—such as asthma, diabetes, cancer, or renal disease—subject to flare-ups or complications, the parent/guardian should assist the nurse in preparing the child's individual health-care plan. If the child needs medications, treatments, or procedures administered while in the school setting, the parent/guardian is responsible for providing the medication and, in some instances, supplies and equipment necessary for the district to provide such care. Of course, the provision of those materials and the subsequent care must comply with district policies.

Students

Students are also responsible for complying with rules and regulations designed to protect their safety and prevent injury and protect the health and safety of others. For example, when an injury or illness occurs, students are responsible for informing teachers, staff members, or school health personnel that they need care. If the student has a chronic health problem, it is preferable that the student, the family, and school staff members collaborate in planning, implementing, and evaluating the individualized health plan (IHP).

Local Health Departments and Health Officers

Local health departments and officers are required to protect the public's health and welfare. In meeting these requirements, local health departments (LHDs) are responsible for carrying out the core public health functions of assessment, policy development, and assurance as set forth in Wis. Stat. 251. To that end, they are required to provide basic public health services as well as ensure conditions conducive to the population's health and welfare. The five basic public health services are:

- surveillance, investigation, control, and prevention of communicable diseases
- a generalized public health nursing program
- disease prevention
- health promotion
- human hazard prevention and control

Health departments have many required functions and responsibilities and can be a valuable partner for schools. Collaboration between school districts and the local public health department is highly recommended, particularly as it relates to student health promotion and disease prevention. Such collaboration is also important because additional school health services may be available to the school district from the health department, either at no charge or through contractual agreement—as set forth in Wis. Stat. 120.13(11).

Others

Other school-based and community-based health-care providers may also be responsible for managing acute and chronic child health problems with families and schools. Physicians and other health-care providers may assist or play key roles in the management of common illness and injury. Such services may, in addition to traditional school health services, include the provision of environmental safety services, screening, consultation, other resources and equipment, or inservice programs. Districts are well advised—in accordance with state and federal laws and with the cooperation of the school nurse, medical advisor, and school health advisory committee—to adopt and implement policies outlining the use of such outside service providers.

Sharing and Updating the Health Services Policies

The school district's health services program should outline in writing the management of common illnesses and injuries as well as common chronic conditions and should be made available to all school administrators, faculty, and staff members. The district should provide an annual overview of the health-services program as a district inservice. Information about the management of injuries and illnesses at school should also be included in each family's school handbook and presented in group settings such as Parent Teacher Association meetings, student assemblies, and open house events. Illness and injury policies must be reviewed annually by the school nurse, medical advisor, administration, and school health advisory committee and be revised as needed.

Managing Injuries and Illness

In the comprehensive school health program described in Chapter 1, management of student illnesses and injuries is one of the school health programs districts provide through the student-services component. In addition to providing direct nursing services as needed, the school nurse is responsible for and manages the

- assessing and treating of common illnesses and injuries during regular school activities on site and during school-sponsored activities off-site;
- establishing standing orders and health-services guidelines;
- creating student emergency information and health-problem lists;
- developing and implementing individualized health plans;
- recruiting, training, monitoring, and supervising nonprofessional school health personnel;
- equipping and operating health rooms;
- documenting school health services and recordkeeping;
- communicating with parent(s)/guardian(s), school staff members, and community health-care providers; and
- communicating the health-services plan.

The methods used to address these activities will vary from district to district, depending on the financial, human, and material resources available to the district.

Off-Site Care

The school nurse should develop guidelines for managing common illness and injury during school-sponsored activities outside the school building such as field-trips, athletic events, and music competitions. An individual trained to provide first aid and implement school district guidelines must be available and should be equipped with a variety of support equipment for out-of-school activities, including:

- a cellular phone or other device/system for contacting emergency personnel;
- student emergency information cards and, if needed, an IHP;
- a portable first aid kit or box (a tackle box works well) with equipment needed to treat minor injuries, documentation forms, and containers for biomedical waste;
- a locked container for storing students' medication; and
- any additional emergency equipment as directed by school district guidelines, such as a microshield should CPR be necessary.

Practice Protocols

Practice protocols are developed collaboratively by the medical advisor and the school nurse and may be included in district guidelines. Student-specific orders are developed by the child's health-care provider in consultation with the school nurse and are part of the child's individualized health plan. Permission from the parent(s)/guardian(s) must be acquired for implementing either of the two types of orders: *general* or *specific*.

General orders apply to any student for whom the order may be applicable. An example is the administration of an appropriate dose of acetaminophen for fever, headaches, sprains, or menstrual cramps.

Specific orders are prescribed for individual student conditions. An example is administering glucagon to a diabetic student exhibiting signs/symptoms of low blood sugar. (For an example of a standing order for anaphylaxis, see Chapter 9, Figure 28.)

The registered nurse and a medical advisor review general orders on an annual basis and revise as necessary. Samples of protocols and standing orders can be obtained from the School Health Alert (listed in Chapter 13, "Resources").

Written Guidelines for Managing Illnesses and Injuries

Written guidelines can prove quite valuable to a district in addressing issues related to the effective management of common illnesses and injuries. Such standardized guidelines help ensure that students receive safe, consistent management of common illnesses and injuries found in the school population.

Guidelines should include but need not be limited to

- a definition of the problem or description of the disease;
- identification of common signs and symptoms;
- initial management, such as immediate care;
- secondary management, such as referrals;
- special instructions, such as when to contact the student's parent(s)/guardian(s), the school nurse, the principal, and the district administrator;
- documentation; and
- follow-up.

Guidelines can be drafted by small groups of nurses and others using appropriate references. Representatives from the school administration; public health officials; the medical, dental, and nursing communities; health and physical education teachers, and parents should review drafts. The school board should then formally approve the guidelines before they are implemented.

District policies must clearly define which individuals are responsible for implementing and evaluating the guidelines.

Emergency Information Cards and Health-Problem Lists

Emergency information cards provide essential information to those persons who may be called upon to provide care to students suffering from injuries or illnesses. (Essential information recommended for inclusion on the cards is contained in Chapter 9.)

These cards allow nurses to prepare in advance for special circumstances which may arise or for any special equipment that may be needed in the event a particular student's condition demands it—as might be the case with a student having asthma, allergies, diabetes, or a seizure disorder.

Parents must complete or update emergency information cards annually for every student. The administration should keep these cards in a centrally located office, accessible to school health personnel, teachers, and others who need the information.

Prior to the beginning of each school year, the school nurse should review the emergency cards and compile a confidential health-problem list. This information should be used to prepare for routine and emergency student health needs throughout the district. The school nurse should also update the health-problem list at regular intervals throughout the school year. Information on the list is confidential and should be treated in the same manner as all confidential health records.

Individualized Health Plan (IHP)

When a student requires health care in school, whether for a chronic problem (such as diabetes) or problem limited in nature (such as a fractured leg), the school nurse will develop an individualized health plan (IHP) in cooperation with the student (if possible), family, physician, school health personnel, and the student's teachers (see Figure 25). The IHP is prepared by the school nurse and is individualized to reflect the student's specific needs, health-care services required during the school day, expected outcomes of the care, and documentation necessary for claiming third-party reimbursement.

The purpose of the IHP is to ensure that a student benefits from the school's educational program by efficiently and effectively providing the health-care services necessary to facilitate such learning in a safe environment, with minimal disruption to the normal activities of the student and of classmates. The IHP should be developed in such a way as to support the student's ongoing participation in academic and extracurricular activities—such as field trips and, where appropriate, participation on athletic teams—with classmates and to create a safe process for the delegation of nursing care. Because of the potentially wide-reaching impact of the IHP, nurses should work with the student, family, administrators, teachers, coaches, and others to ensure the safe delegation of care to capable, trained providers.

The first step in developing the IHP is the assessment of the student's condition, academic and extracurricular demands, and resulting school health-service needs. This assessment—considered a function of standard nursing and medical practice—must be conducted by the nurse; it may not be delegated to or assumed by others. Assessments typically address:

- physical findings, needs, and adaptations;
- student strengths and coping strategies;
- social and emotional relationships;
- family issues; and
- available and needed resources, including personnel, equipment, and training.

With that information in hand, the nurse should seek to answer the following questions when formulating educational and health plans (from *The School Nurses' Source Book of Individualized Health Care Plans* (1992)):

- What is the student's diagnosis and prognosis?
- Is the student's health stabilized and predictable, or does it change frequently?
- How much does the student know and understand about his/her health condition and status? How has it been explained to the student? Are further explanations or continued reinforcements needed?
- What medication(s) is the student taking? How will they affect the student's behavior and ability to learn? Will they need to be administered on a routine, episodic, or emergency basis?
- What specialized health-care services is the student currently receiving? Will any of these need to be administered in school? Is the student able to carry them out at home?
- What is the student's physical endurance? Is there a need to modify the student's scheduled activities?
- Does the student require classroom modifications, such as preferential seating, a special desk or table, or special equipment?
- Does the student's condition require special restrictions or additions to classroom, physical education, or recess activities?
- Can the student participate in extracurricular activities?

In addition, the nurse will want to ask, Does the student...

- require a special or modified diet?
- require special transportation to/from school?
- have mobility problems that require assistance in school?
- need special consideration in a building evacuation plan?
- need assistance with daily living activities, such as the use of toilet facilities?
- have difficulties or need assistance in communicating?
- have a chronic condition which may lead to medical emergencies? Has a Child Alert 1033 plan been established with the local emergency medical service for this student?

The IHP will also explain the student's specific health-care needs, health services required during the school day, and expected outcomes. IHPs should address, but not be limited to

- assessment of the student's health needs
- behavioral objectives and goals
- interventions
- care providers and their responsibilities
- parent and physician authorization for medication and health procedures
- emergency plans
- transportation plans
- school adaptations
- personnel training needs
- resources required to implement the IHP
- evaluation plans and re-evaluation dates

IHPs are recommended for students with any of the following conditions, among others:

- allergies
- arthritis
- asthma
- cardiovascular disorders
- cystic fibrosis
- diabetes
- enuresis
- encopresis
- immune disorders
- musculoskeletal disorders
- neuromuscular disorders
- respiratory disorders
- seizure disorders

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Figure 25

Individualized Health Plan (IHP)

Full Name of Child	Date of Birth	Grade
School	IHP Beginning Date	IHP Ending Date
Name of Parent/Guardian	Home Phone *Area / No*	Work Phone *Area / No*

Related Services/Resources	Reviewed/Revised
Health Care Provider	Telephone *Area / No*

Special Health Need(s)

Person Responsible for IHP Completion	Position
Persons Participating in IHP Completion 1 2	Position 1 2

A. Summary of Present Health Status *Include screening and assessment of data*

B. Nursing Diagnosis(es)

Plan Implemented By	Plan Monitored By

Parental Approval *Optional*	Date

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Individualized Health Plan (for health needs that may result in an emergency and/or need management or monitoring)

Student Name

Date

Nursing Diagnosis

C. Student Goals *Include baseline data for short-term goals.*

Objectives (Expected Outcomes) (No. 1.1, 1.2, 2.1, etc.)	Interventions	Person(s) Responsible

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A student who has a health condition may be prone to injury or exacerbations of the illness. An IHP will help ensure an effective response when managing those student health needs and possibly prevent a nonemergency situation from becoming an emergency situation.

The IHP should be on file and readily accessible to those responsible for implementing it. The IHP should be reviewed and updated by the registered nurse at predetermined intervals.

Training Nonprofessional School Health Personnel

The school may designate care of students with illnesses or injuries requiring basic first aid to trained personnel in compliance with school district policies and procedures. Local school board policies, school personnel job descriptions, and possibly a collective bargaining unit articulate, in part, the first aid and medication administration responsibilities of nonprofessional school health personnel. (Schools should consult the Wisconsin Nurse Practice Act for more information regarding the provision of services beyond basic first aid and oral medication administration.)

The registered nurse is ultimately responsible for determining who carries out delegated nursing activities. State licensure holds registered nurses accountable for delegated nursing care and requires that they provide ongoing training, monitoring, and supervision of nonprofessional school health personnel.

In accordance with Wis. Admin. Code N6.04, licensed practical nurses (LPNs) may provide basic care for students in schools under the general supervision of a registered nurse or the direction of a physician, podiatrist, or dentist. LPNs may only accept basic-care assignments that they are competent to perform. When the assignment includes complex care, the LPN must work only under the direct supervision of a registered nurse or physician.

The School Health Room

Schools vary greatly in the amount of space available for health-service activities. To avoid the possibility for confusion in the midst of individual or group health-service needs, each school building needs to identify a location where students can go when ill or injured, where teachers and staff know health-care resources are available, and where students' health problems can be addressed promptly and empathetically. The room should have a telephone and provide privacy, essential for conversing with and examining students. (See Chapter 9 for a sample description of basic health room features, furnishings, and essential equipment.)

School districts should have guidelines in place that allow equitable allocation of health-care resources, personnel, and equipment to each school building. Allocation formulas are available to aid in this endeavor (see Appendix C). The nurse or other trained person should uniformly stock each building with common durable and nondurable equipment necessary for the management of common illnesses and injuries. The nurse should also evaluate any special needs that the student population dictates. For example, a student with diabetes will need additional equipment and privacy to manage potential insulin reactions.

Documentation

Individuals who provide care for students with illnesses or injuries must document those services. Documentation may take the following forms:

- a written log of information regarding injury and illness care, including the student's name, the time of the contact, reason for the contact, type of care provided, disposition of the student, and signature of the individual providing care.
- a record of any contact with a student for management of an illness or injury placed in the student's health record according to school district policy.
- an accident/injury report sent to the principal and safety committee detailing serious injuries that occur in the school building, on school grounds, or during school-sponsored activities off school grounds.

Health room logs and health records are confidential and should be maintained in locked filing cabinets.

Communication with Parents and Legal Guardians

Clearly, schools should promptly contact a student's parent(s)/guardian(s) in an emergency situation.

School personnel should inform parent(s)/guardian(s) in writing or by telephone about a student's illness or injury if the

- illness or injury will affect the child after the school day ends.

- contact results in a change in the home management plan (such as an asthmatic using an inhaler to relieve wheezing at school).
- student needs to be sent home or seen by a health-care provider to treat the illness or injury (such as acute otitis media or fractures).
- student must be excluded from school until the illness (such as conjunctivitis/pink eye or head lice) is adequately treated.
- the situation requires a home visit.

Minor illness or injury does not usually require exclusion from the school setting unless the

- condition prevents participation in school activities.
- student poses a significant health risk to others in the normal course of school activities.
- signs/symptoms suggest severe illness or immediate medical intervention is needed.
- signs/symptoms suggest communicability.

Notes sent home should contain information regarding

- the situation that took place in the school or on school grounds or at a school-supervised off-site activity,
- what was observed,
- how the situation was managed,
- recommendations for the family, and
- the signature of the person completing the form and a phone number at which school health personnel can be reached for clarification.

Acute and Episodic Health Problems

Many signs and symptoms of common illnesses and injuries are readily identifiable. Districts should develop guidelines for managing health concerns that arise during curricular or extracurricular activities either on or off the school grounds.

The Wisconsin Communicable Disease Chart (available from the Communicable Disease Section, Department of Health and Family Services) identifies those diseases which must, under Wisconsin law, be reported (see Figure 19), including information regarding signs, symptoms, and public health responses (see Appendix PP, "Common Health Conditions in School-Age Children").

Chronic Illnesses

The impact of chronic illness on students is immense. A child with a chronic medical condition may be at greater risk for acquiring common childhood illnesses or may experience exacerbations of the chronic problem or complications from accidental injury. Such events also create additional complications, including:

- episodic and/or lengthy absences from school,
- limited/reduced endurance and/or concentration, and
- an increase in daily health-management demands which adversely affect academic success and the development of social skills.

The school district, in cooperation with the family and health-care providers, must provide an appropriate educational and related service program based on each student's unique educational, developmental, and health-care needs. Because health conditions are unique, individualized assessments and decisions are critical.

Children with chronic health conditions should be identified on initial school enrollments and through annual health status updates. An IHP that addresses day-to-day concerns and management of exacerbations of the illness should accompany most students with chronic illness. (Appendix QQ, "Common Chronic Health Conditions in School-Age Children," lists a number of these conditions and considerations for managing them.) If the illness affects a student's educational performance, the IHP may be incorporated in the IEP of children covered by IDEA-R97, or by an accommodation plan under Section 504 of the Rehabilitation Act of 1973.

In addition, most students with chronic conditions need a case manager who is responsible for establishing and maintaining communication and coordination with the student's family, health-care and community providers, and school staff members. In most instances, the school nurse is the most appropriate and knowledgeable person to provide case-management services. However, in some instances collaboration and consultation with student services collegues and local public health nurses may be a valuable resource in case management and care coordination.

Other Health Conditions and Concerns

Other noninjury or illness-related health conditions exist which the school district may need to address. As with any health concern, when managing other health conditions, the school nurse should consider:

- emotional and physical factors
- ethnicity and cultural diversity factors
- sexual orientation

School health personnel, administrators, and educators must provide school health services that build on individual and family strengths while respecting the student's unique personal experience.

Alcohol and Other Drug Abuse

School board policies must address the presence and/or use of alcohol and drugs in the school. Students who use alcohol or drugs can benefit from a coordinated intervention plan involving school health personnel, the student's family, and community service providers. In many cases, community intervention may be undertaken before members of the school health-services and student-services teams are involved. However, including both parties ensures that the student is instructed, encouraged, and supported in a manner conducive to the successful treatment of the health condition.

Eating Disorders

Obesity

From 10 to 30 percent of all adolescents struggle with the problem of obesity. These children are at risk for physical manifestations including:

- high blood pressure
- elevated blood lipid levels
- iron-deficiency anemia
- exacerbation of pre-existing conditions, such as juvenile rheumatoid arthritis

Obese children may also have a distorted image of their body and, consequently, low self-esteem. (For more information on student self-reporting of food consumption, diet, and exercise, see the "Youth Risk Behavior" section of Chapter 1.)

Treatment may involve reducing the number of helpings and/or the size of portions, increasing the frequency and regularity of physical activity, and/or slowing the weight gain and letting the child "grow into their weight" rather than diets and weight reduction.

Anorexia and Bulimia

For many young peple, adolescence is characterized by a preoccupation—fostered, in part, by a cultural emphasis on thinness—with appearance, especially body weight, which often contributes to low self-esteem. This influence, sometimes joined with communication problems within a family, often leads to eating disorders, which a student may wrongly view as a demonstration of self-control.

The consensus (Patton, 1992) is that eating disorders result from the influence of a number of factors, including:

- sociocultural
- developmental
- cognitive and behavioral
- genetic
- psychological
- familial

A number of physical symptoms are evident among students with eating disorders, including:

- an inability to recognize or express feelings
- depression
- sleep disturbances
- irritability
- fatigue
- amenorrhea
- difficulty concentrating
- decline in academic performance

The highest incidence of anorexia (excessive dieting) and bulimia (repetitive binging, then purging) exists among girls ages 14-18 years. Recurrence is common, and denial of anorexia and bulimia is often significant until the symptoms become profound. Early diagnosis is essential.

Among the more acute consequences of eating disorders, particularly those which include vomiting and decreased food intake, is electrolyte imbalance, which can lead to cardiac arrhythmia and cardiac arrest.

Neumark-Sztainer (1996) notes that research on the etiology of eating disorders has provided significant insight regarding the factors which need to be addressed when working with students with eating disorders. However, Neumark-Sztainer also notes that research has not offered any direction on who should be targeted for prevention or what approaches would optimize prevention efforts. Whatever the circumstances, most experts agree that students need to be approached in a nonjudgmental manner by those who respect the student's reluctance to discuss food-related behavior.

Since eating disorders may be present in more than one generation of a family, nurses may find it helpful to carefully review and update student health information, including information on

- family history
- weight and nutrition
- reproductive activity
- psychosocial considerations
- physical examination findings

Working with the student, family, and other school and community health-care providers, the nurse can develop an optimal plan that includes prevention, monitor the student's progress in dealing with eating behaviors and nutritional health, and refer the student for additional services as needed.

Pregnancy

The stress of early child-bearing on adolescent woman can adversely affect both their attendance and academic performance. Such young women are at increased risk for anemia, hypertension, and preterm labor.

To help ensure a successful pregnancy outcome, an IHP should be developed to address issues related to:

- prenatal care;
- educational modifications, if necessary;
- coordination with community health-care service providers; and
- anticipatory guidance.

Anticipatory guidance provides the student with information on what to expect during the pregnancy and how to continue academic studies as the delivery date approaches. The nurse can facilitate a positive emotional, physical, and academic experience for the student by addressing related issues including:

- proper nutrition for the mother and baby prior to delivery
- physical activity
- emotional coping skills
- physiological changes during pregnancy
- signs of potential problems with the pregnancy
- labor and delivery
- maximizing support from family members, friends, and health-care and social-service providers
- parenting roles, responsibilities, and decisions
- infant care
- sexuality
- family planning methods
- personal responsibility
- loss and grieving processes
- school/vocational options and achievement

Psychosocial Conditions

Schools play an important role in promoting healthy emotional and social development for all children. Promoting healthy emotional and social development, including a sense of self-worth, are critical to the success of children within and beyond the classroom. Schools are required by law to identify children with psychological conditions that may put them at risk of having a disability, handicapping condition, or health-related educational or behavioral problem (IDEA-R97, Section 504, 1973) and to ensure proper assessments and appropriate interventions and/or modifications. Some of these conditions may have a physiological base, while others may be a result of trauma, familial, or social stresses and problems. Whatever the cause, it is paramount that schools be alert to these issues.

The school nurse and student services providers are integral to the promotion of positive mental health of students in the school district. In particular, nurses should

- be available to discuss problems and concerns with students;
- screen students who may need further counseling or other health or mental health services;
- refer students to appropriate mental health professionals;
- develop an IHP, when appropriate, for students with mental health issues; and
- assist students and their families in locating needed mental health resources.

School nurses and their student services colleagues can be influential in helping students to develop sound mental health through

- understanding and addressing the unique mental health needs of children and youth;
- fostering a school culture that is conducive to learning and is safe for everyone;
- identifying children and youth at-risk for emotional distress and disturbances;
- helping the school district develop a mental health crisis and intervention plan;
- screening children and youth who appear to have emotional disturbances for indications of physiological conditions that may be contributing to their behavior;
- establishing formal relationships with service agencies, community-based organizations, and parents to develop a plan for children with mental health problems; and
- providing training about child and adolescent emotional and psychological development to help

school personnel understand and respond appropriately to mental health issues.

The major causes of mortality and morbidity among children and adolescents (accidents, homicide, suicide, substance abuse, and sexually transmitted disease) are preventable. Primary prevention strategies may consist of providing children in advance with the resources and skills necessary to cope with complex life situations. Such skills can help students gain competence and self-worth, which is critical to emotional well-being. Teachers, principals, student services providers, and other school staff members play important roles in building a positive classroom and school environment for students. Curricular and other activities may include problem-solving class meetings, communication skills, conflict resolution with other students and adults, and opportunities for positive emotional expression.

In addition to organizing and facilitating student-focused prevention activities, student services providers, including school nurses, play an important role as organizational consultants. They can help schools maintain nurturing environments, support the mental health needs of staff, and provide consultation to school staff about managing a variety of problem behaviors by helping develop policies, procedures, and/or guidelines to respond to mental health needs and related issues.

Secondary prevention efforts may focus on identifying and providing services for children who are at risk of developing emotional, behavioral, or other school-related problems. Children who may be at risk for developing these types of problems may include those with family or learning problems, siblings of a child with complex special health-care needs, or those experiencing the loss of a person that is close to them. Because teachers are in daily contact with students, they may be in a position to identify children at risk for developing emotional, behavioral, or other school-related problems.

Typical examples of secondary prevention are (1) facilitating group counseling with a trained mental health professional who works with siblings of children with special health-care needs or (2) obtaining grief and loss counseling for who have lost a classmate through death. A number of screening tools exist to help assess children who may be at risk for emotional and/or behavioral problems (Achenbach, 1991; Beck, 1993; Conners, 1989; Goldring and Cohen, 1988).

The third level of prevention consists of providing services to children who are actively demonstrating emotional, behavioral, or other school-related problems. In these cases, trained school staff in cooperation with mental health providers may provide concentrated support, follow-up, and case management for students are who acting out or showing other emotional or behavioral problems or for students transitioning back to their home school following day, hospital, homebound, or residential corrections treatment. Students may be seen in small groups or for individual counseling sessions. Schools may provide tertiary services within the district when mental health expertise exists within the staff or may develop linkages with community mental health programs to provide the necessary expertise or services.

Common psychological problems may include, but are not limited to depression, suicidal tendencies, school avoidance, divorce, disruptive behavioral disorders, post-traumatic stress disorder, and attention deficit disorder. A full discussion of these common psychological problems and their prevalence among school-aged children and youth is beyond the scope of this chapter. Readers are referred to more comprehensive texts for information and management of common psychological problems. It is important to note that these conditions and more complex psychiatric conditions may require clinical psychiatric treatment. If left untreated, these conditions can

- impair social skills,
- disrupt the development of age-appropriate competencies, and
- slow cognitive development.

In assessing psychosocial disorders, one should consider

- any previous history of affective disorder
- family history
- alcohol and other chemical use or abuse
- history of life changes
- behavior problems
- threats or attempts of suicide

Following a medical evaluation and diagnosis, the nurse, in consultation with other health-care and social-service professionals and school staff members, may develop an IHP for the student including:

- medication administration
- behavior modification
- modification of the school environment
- coordination of care and services with community support systems

While the principle of confidentiality is an overriding consideration in much of the work of the school nurse with children, the nature of psychosocial conditions and their management demands particular attention to confidentiality.

Violence

Changes in society have made violence a part of day-to-day life for many school-age children as well as a pressing public health issue.

To turn the growing tide of violence against and among youngsters, school health curricula should address

- violence prevention
- conflict resolution
- anger management
- life-skills training

When treating an injury associated with violence in school, it is important to determine how the injury occurred, if the conflict was settled, and whether it may lead to further violence.

If the child is in a violent situation which could lead to imminent harm, *confidentiality no longer needs to be maintained*. Consulting with the principal, families, police, and other authorities as soon as possible is advisable.

Environmental Safety

Wallace et al. (1992) estimated that students spend an average of 14,000 hours in schools from kindergarten through 12th grade. While students in school face a number of common environmental concerns—for example, noise pollution, which can diminish learning potential, and overcrowding, which can enhance the spread of infection—other more serious concerns make it imperative that districts ensure that students spend their school days in a safe and healthy environment.

School districts and local health departments share responsibility for providing a safe school environment. Because the school is responsible for the physical state of the buildings, districts need to clearly identify who is responsible for maintaining each part of the physical plant so that appropriate maintenance and repair referrals can be made as necessary. The local health department has a statutory responsibility to inspect schools for environmental deficiencies and public health hazards.

Airborne and Environmental Irritants

Management of certain illnesses and injuries may need to include an assessment and modification of environmental hazards which may cause stand-alone diseases or exacerbate conditions like asthma or allergies. Environmental triggers may include:

- pollen, grass, and trees
- dust, mold, pet dander, and dampness
- cleaning agents, paint, and markers
- asbestos and chalk dust
- perfume
- passive smoke from tobacco products
- smoke and pollutants from burning leaves or refuse

Among other contributing factors which may exacerbate chronic illnesses are temperature extremes, emotional stressors, and physical exercise.

Asbestos and "Sick" Buildings

Older buildings present different environmental hazards than newer ones. Managing asbestos—a known carcinogen—is a major challenge present in buildings constructed in the 1950s and 1960s. With their emphasis on energy efficiency, the design of newer buildings results in tight construction that reduces air exchange and may contribute to "sick-building syndrome." People working and learning in sick buildings complain of mucous membrane and upper respiratory irritation in addition to general symptoms of headaches and fatigue.

Classrooms

Teachers must safely store hazardous classroom materials, such as chemicals and equipment used in experiments, and provide students with safety equipment for handling them. In addition, students who operate heavy machinery should do so only after being properly trained and only under the direct supervision of qualified teachers.

Lead Poisoning

Children can ingest lead contained in lead-based paint and contaminated soil, dust, food, and water. Exposure can occur in the family hobby shop (where lead-based materials may be used in furniture refinishing), in the family living area (particularly in older homes), and outdoors.

Lead can have a devastating effect on the central nervous system, particularly in younger children. Even relatively low lead levels may cause diminished intelligence, impaired neuro-behavioral development, decreased hearing acuity, and retarded growth. Higher lead levels can result in severe damage to the central nervous, renal, and hematopoietic systems and even in death.

The most common environmental treatment is the removal of the lead source from the child's environment. Physicians may also choose or be compelled to treat the child via intensive drug therapy.

In spite of the wide recognition of the danger lead poses to young children, debate continues over if, when, and how many children should be screened for lead poisoning. Currently, the Centers for Disease Control recommends that children who are exposed to several risk factors begin annual screening at the age of 18 months. (For more information, see DPI Bulletin 94.05, "Lead Poisoning Prevention.")

Fire and Tornado Drills

All schools must adhere to fire and tornado drill regulations. All students and staff members should be advised of and trained in the proper fire and tornado response procedures. Districts should consider the needs of students and/or staff members with disabilities or limited mobility as well as the procedures that should be followed by students and staff members in locations other than the school's ground floor when such an event occurs.

Lunch Rooms

Dining and food preparation facilities must be sanitary and contain proper food warming and refrigeration equipment. Employees must be healthy and wear proper regular and protective clothing.

In addition, training for lunch room employees in administering the Heimlich Maneuver may prove highly valuable in the event a student or staff member is choking from food lodged in the throat. CPR training could prove equally valuable in the event that a student's or staff member's heart stops beating.

Playgrounds

As one of the school sites bearing the greatest potential for fun, physical development, *and* injury, the school playground should be inspected frequently to ensure that the area is safe and that equipment is in good repair and meets minimum safety standards. Staff members and volunteers also need to establish and enforce safety rules.

All physical activity involves risk taking, and because children may not fully comprehend their own physical limitations, playgrounds should not contain items that can cause injury in the natural course of play.

According to the Consumer Product Safety Commission, a number of key issues should be addressed when providing opportunities for and monitoring children's play:

- The playground should be designed with appropriate space between each piece of equipment and between the pieces of equipment and structures such as buildings. This will allow students to move from one activity to another safely without being unduly confined or exposed to the risk of being injured by others who are playing.
- The surface underneath play equipment should consist of impact-absorbing material which adequately protects against the height and types of falls which may occur in the course of their normal use.
- Schools should follow all manufacturer maintenance recommendations and inspection schedules.
- All hazards should be repaired or removed, including visual barriers.
- Reasonable, appropriate access should be provided for children with disabilities.
- Playground supervisors should be positioned for optimum visual access to all students.
- Schools should establish and clearly communicate to parents and students rules regarding clothing and playground conduct.

Pedestrian Safety

Because they are increasingly responsible for getting themselves to and from school, children from five to nine years of age are most likely to be injured as pedestrians. In part, the high incidence of such injuries among children in this age group is the result of their

- limited ability to judge their distance away from and the speed of approaching automobiles,
- small physical stature,
- poor impulse control, and
- difficulty determining the direction from which sounds are originating.

Working with students, families, and community agencies, schools can

- offer and reinforce pedestrian education/safety programs,
- help identify and correct community hazards that may contribute to pedestrian injuries,
- promote the use of reflective clothing and other safety accessories by those walking in the dark,
- develop safe pedestrian crossing areas and walking policies near bus and automobile traffic, and
- enforce pedestrian-related traffic laws.

Bicycle Safety

Bicycle safety, particularly the promotion of bicycle helmet use by children, is one of the fastest growing areas of activity among injury-prevention professionals as well as being a growing area of concern among parents. Most bike-related deaths result from head injury, and most bike-related injuries result from falls and collisions with objects, pedestrians, and other bicyclists. Research (Wasserman et al., 1988) suggests that using approved bicycle helmets (ANSI or SNELL) may reduce head injuries by as much as 85 percent.

Opportunities to offer and reinforce bicycle-safety messages and activities may be best addressed through the collective work of parents, school personnel, and municipal and community agencies. Suggested activities for schools include but are not limited to:

- teaching bicycle safety as part of the health, language arts, or science curriculum;
- developing a policy requiring bicycle helmet use for students riding bicycles to and from school;
- encouraging the purchase and wearing of bicycle helmets;
- modeling safe bicycle behaviors among staff riding bicycles to and from school;
- reviewing and reinforcing bicycle-injury prevention strategies when caring for students following a bike injury; or
- supporting municipal and community agencies that organize discounted bulk purchases of bicycle helmets and distribute them at bicycle-safety courses.

School Bus Safety

Annually, more than 500,000 Wisconsin children are transported by school buses.

In spite of a number of recent accidents making state and national news, school buses remain one of the safest means of transportation. When accidents do occur, they do so most often among children between the ages of four and seven, according to the U.S. Department of Transportation, which also notes that two-thirds of all deaths occur as children get on or off the bus.

To ensure the safe transport of children on buses, districts should regularly educate students and parents on safe drop-off, pick-up, and riding guidelines and behaviors. Districts should also work with local law enforcement agencies to ensure proper enforcement of school bus-related traffic laws.

The Wisconsin School Bus Association offers a number of recommendations to ensure a safe bus transportation experience:

- All bus exits should be unlocked and able to be opened by riders in the event of an emergency.
- Riders should use seat belts when riding on buses equipped with them.
- After the bus driver has given a signal to board or cross the street, riders should look both ways before crossing.
- Riders should avoid wearing clothing with toggle drawstrings.
- Riders should fill open seats beginning from the front and moving back, avoiding seating in the last two rows, whenever possible.

In addition, schools should give special consideration to providing safe transportation for students with special health-care needs or limited ability and to those who may require special health-care equipment when being transported to and from school.

For more information on safety issues related to school buses, contact the Wisconsin School Bus Association, 1015 Erie Avenue, P.O. Box 168, Sheboygan, WI 53082-0168; (920) 457-7008.

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Emergency Services 9

Introduction

School health services have traditionally focused on improving student health through education, prevention, screening, referral, and follow-up. However, emergency care remains a reality that school health-care providers must face.

Even though they know problems may arise, parents expect that their children will be safe at school and trust that emergency medical concerns will be addressed swiftly and skillfully. This is not just the wishful thought of parents, but the law, as enacted by the Wisconsin legislature.

School districts evaluating their emergency nursing services should keep in mind that adequate preparation is paramount, particularly in a day when student needs and medical standards are more complex and specific than ever before. An emergency-in-progress does not offer an ideal setting in which to discover the weaknesses of poorly conceived emergency services. Moreover, a mismanaged emergency may be seen by the community as an avoidable tragedy and a betrayal of its trust in the management of the school district.

While local medical resources may vary from one community to another, the needs of a sick or injured child usually do not. Wis. Stat. 121.02(g)—entitled Emergency Nursing Services, but widely known as "Standard (g)"—provides a solid foundation upon which to build a medically sound and cost-effective school emergency nursing service. This chapter provides an overview of the requirements of Standard (g) and suggestions on how a district, its students, employees, and citizens can best meet them. That goal will be achieved, in part, by addressing

- legal considerations
- school emergencies in perspective,
- formulating policies, and
- the "Five P's"—personnel, physical plant and equipment, protocols, practice, and playback.

Legal Considerations

Wis. Stat. 121.02(1)(g) and Wis. Admin. Code PI 8.01(g), commonly referred to as Standard (g) requires each school district to provide emergency nursing services under a written policy adopted and implemented by the school board. Such services must meet all of the following minimum requirements:

1. The emergency nursing policies shall be developed by a professional nurse or nurses registered in Wisconsin in cooperation with other school district personnel and representative from community health agencies and services as may be designed by the board.
2. Policies for emergency nursing services shall include protocols for dealing with student accidental injury, illness, and administration of medication at all school-sponsored activities including but not limited to curricular, cocurricular, and extracurricular activities and a method to record each incident of service provided.
3. Arrangements shall be made with a licensed physician to serve as medical advisor for the emergency nursing services.
4. The emergency nursing services shall be available during the regular school day and during all school-sponsored activities of pupils.

5. Student emergency information cards, equipment, supplies, and space for the emergency nursing services shall be appropriate and readily accessible.
6. A review and evaluation by the school board shall be made of the emergency nursing services program at least annually.

School Emergencies in Perspective

While the incidence and management of illness and injury in schools have not been well studied, available data reveal that injuries are rarely caused by random, uncontrollable events. Rather, they are preventable and predictable with identifiable risk factors. A review of National Pediatric Trauma Registry data (1989 to 1993) by the Children's Safety Network (1996) revealed the following information about school injuries:

- Males were injured at school more than twice as often as females (71 percent vs. 29 percent).
- Of those injured in school, 18 percent had a preexisting medical condition (such as a physical or mental disability or chronic illness).
- Forty-one percent of injuries happened in recreational areas rather than in the school building or other facility.
- Violence (gunshot wounds, stabbings, beatings, and being intentionally struck by an object) accounted for 10 percent of school-related injuries.
- Falls were the most frequent cause of injury (46%), followed by sports activities (30%) and assaults (10%).
- Other major causes of injuries at or near school included pedestrian, bicycle, and bus collisions.

The Children's Safety Network noted that, although these data are not population based and reflect only injuries resulting in hospitalization, the general information about childhood injuries in school is valuable. For example, of the 421 falls evaluated, 30 were from a height greater than 89 feet, including 13 from windows, roofs, or balconies. Falls accounted for three out of five deaths, five out of nine cases requiring extensive rehabilitation, and half of severe-injury cases. Among athletic injuries, sports most commonly causing injury were football, basketball, wrestling, track and field, soccer, and gymnastics. Assaults included beatings, gunshots wounds, falls from pushing or shoving, stabbings, and being struck by a blunt object.

Further, a major concern identified by the NPTR is that many school children are not receiving appropriate triage for injuries sustained in school or in school-related activities. The data revealed that many school injuries were not treated immediately. For instance, 16 percent of the children sent home after being injured were subsequently admitted to a trauma center, including six stabbing cases.

Formulating Policies

Standard (g) gives local school boards ultimate responsibility for developing formal policies for providing emergency nursing services at district-controlled sites and functions. Such policies should not be limited to providing services to students alone but should also include policies relating to providing services to faculty and staff members.

While the school board has the right and obligation to adopt the best and most cost-effective policies it can, Standard (g) recognizes that boards may lack the necessary expertise to do so. Thus, Standard (g) specifies that the board delegate policy development to a professional nurse(s), in cooperation with the medical advisor, other school district personnel, and community health services. In fact, broad community involvement is highly desirable, as board members may be less likely than the school nurse to know what community resources are available. It is recommended that team members meet some minimum qualifications:

- *Expertise in managing pediatric emergencies.* Course work may include a Pediatric Advance Life Support Course (American Heart Association/American Academy of Pediatrics) or the Advanced Pediatric Life Support Course (American College of Emergency Physicians/American Academy of Pediatrics). Pediatric nurses, pediatricians, family practitioners, emergency physicians, and rescue personnel may have such experience and training. The involvement of area emergency medical services from the beginning of the district's policy and procedure development process is also essential because it can facilitate the delivery of appropriate and timely services when an emergency occurs. In addition, the input of parents—particularly those whose children have special health-care needs—is vital.
- *Availability for meetings and discussions.* The unavailable expert is useless. Individuals who agree to serve as advisors should be made aware of and agree to the anticipated time commitment.

- *A spirit of cooperation.* An atmosphere that stifles the free exchange of ideas will more likely engender animosity and resentment than produce a satisfactory result. Those chosen for this important task must have a demonstrated ability to consider and respect others' opinions.

The development of an effective emergency nursing service depends on five critical contributing factors known as "The Five P's":

- personnel
- physical plant and equipment
- protocols
- practice
- playback

Personnel

It is crucial to choose the proper number of trained responders. An arbitrary student/staff-to-responder ratio may not address the need adequately, since other factors—including physical surroundings, activities and specific risks, special needs of participants, and the responders' level of training—affect staffing decisions.

When making staffing decisions, many districts rely on the participation of untrained support personnel, including:

- teachers
- teacher aides
- coaches
- crossing guards
- bus drivers
- custodians
- secretaries

Consequently, district job descriptions should detail the health-care responsibilities which staff members may be asked to undertake in the course of their normal duties. The district should also provide appropriate life-support and first-aid training.

Regardless of who is ultimately assigned a given task, an effective communication system linking all staff and volunteer service providers is essential.

Standard (g) requires school districts to designate a medical advisor who is a licensed physician. When selecting a medical advisor, districts would do well to use the same criteria (expertise, availability, and cooperation) it uses in selecting the designers of the district's emergency services. The medical adviser should be a physician

- skilled in managing pediatric emergencies;
- available for consultation on a regular basis (a scheduled monthly or bimonthly meeting may be advisable); and
- willing to meet with school administrators and other community officials including the medical advisor and local health department personnel, as necessary.

The district should detail the advisor's responsibilities in a written contract, and while *pro bono* ("for the public good and without compensation") service may be desirable, it should not be assumed or expected. The district should outline agreed-on terms of compensation in the written contract (see Appendix RR, "The Physician Consultant: School District Medical Advisory Agreement").

Physicians who are members of large clinic corporations may have to work through the corporate structure regarding compensation, liability insurance, and even contracted services; they may be restricted from negotiating independently with a school district. In addition, physician compensation and immunity do not mix, so attention to liability coverage is important (see Figure 26, "Volunteer Physician Immunity").

Physical Plant and Equipment

School health facilities should be designed to facilitate the short-term provision of acute care.

School Health Office

Details for laying-out and equipping the school health office will vary, depending on a variety of circumstances, including the size and needs of the student population. However, in making such plans, particular attention should be paid to ensuring adequate

- work space
- storage space
- lighting
- plumbing
- communication
- ease of access

The school health office serves multiple functions as a:

- center for providing emergency and general nursing care.
- center where students who become ill, injured, or are suspected of having a communicable disease can wait until they can be placed under their parent's care or return to class.

Figure 26

Volunteer Physician Immunity

In certain circumstances, physicians are statutorily immune from liability for rendering care. Following are statutes in Wisconsin which legislatively deem physicians immune.

Good Samaritans

Any person who renders emergency care at the scene of an emergency or accident in good faith shall be immune from civil liability for his or her acts or omissions in rendering such emergency care. This immunity does not extend when employees trained in health-care or health-care professionals render emergency care for compensation and within the scope of their usual and customary employment or practice at a hospital or other institution equipped with hospital facilities, at the scene of an emergency or accident, en route to a hospital or other institution equipped with hospital facilities, or at a physician's office (Wis. Stat. 895.48(1)).

Public Health Immunization Programs

If a physician is not an employee of the county, city, village, town, or school district; receives no compensation for his or her services; acts under a written protocol to supervise a public health immunization, he or she will be considered a state agent for the purposes of liability (Wis. Stat. 252.04(9)(b)).

Volunteer Health-Care Provider Programs

Physicians participating in a volunteer health-care program offering health-care services to low-income and uninsured persons under a joint application to the Department of Administration with a nonprofit agency in Brown, Dane, Dodge, Fond du Lac, Kenosha, La Crosse, Milwaukee, Outagamie, Racine, Rock, or Sheboygan County are considered agents of the state. The application of volunteer health-care provider is valid for one year and must be resubmitted on a yearly basis (Wis. Stat. 146.89).

Being considered agents of the state means physicians are not personally liable for claims for medical services, that claims must be brought within 180 days of the alleged injury or the date on which the injury should have been discovered, that the attorney general's office will defend the state and agent against the claim, and that the state's total liability is capped at $250,000.

Team Physicians

Physicians volunteering their services at school athletic events and other athletic events sponsored by nonprofit corporations now enjoy immunity from civil liability for acts or omissions in rendering care to participants at athletic events or contests. To be protected from liability, physicians must voluntarily provide the care at the site of the event or contest; during transportation to a health-care facility from the event or contest; or in a locker room immediately before, during, or after the event or contest. The physician may receive no compensation except for expense reimbursement. The law also extends the same liability protection to chiropractors, nurses, emergency medical technicians, physician assistants, and dentists if they comply with the requirements of the law (Wis. Stat. 895.48(1m)).

Source: Wisconsin State Medical Society, *A Physician's Guide to Wisconsin Health Law*, 1997, pp. C33-34

- private conference space where the nurse, student, teacher, parent, or others concerned with health care, counseling, and guidance can discuss specific health problems of individual students in privacy.
- secure area where student health records and medications are kept.
- center for providing common health appraisals.
- resource area for health education materials.
- storage area for health supplies and equipment.

Space is commonly required for waiting and triage, assessment and treatment, health counseling, and storage. Recommended features of a basic school health room include:

- *Location:* A quiet part of the school building, adjacent to administrative offices and student-services personnel, and away from playgrounds, music rooms, gyms, or noisy machinery. The physical layout allows for individual privacy and is reserved for health purposes only.
- *Ventilation:* Climate controls for heating and air conditioning, exhaust fans, and access to fresh air.
- *Lighting:* Proper illumination in the assessment area and bathroom, with provisions for an emergency light source in case of power outage, achieved by both incandescent and natural lighting.
- *Accessibility for the disabled:* The health room, with an adjacent bathroom should incorporate Americans with Disabilities Act guidelines for accessibility.
- *Floor covering:* Easily cleaned hard surfaces to facilitate proper disinfecting of soiled areas.
- *Hot and cold water sources:* Treatment area to allow for dispensing of medications and washing hands and wounds while the bathroom is in use. Bathroom for washing hands and facilitating special needs. Water source for irrigating foreign substance eye injuries.
- *Electrical outlets:* Accessible outlets distributed throughout the health office.
- *Storage:* Wall cabinets and base cabinets/counter tops with one or more that is lockable for medications or items necessary for specialized health-care procedures. Floor to ceiling closet or cabinet for storage of a scale, crutches, wheelchair, stretcher, privacy screen, and other large items.
- *Equipment:* Refrigerator with freezer or icemaker adequate for storing medications, foods, and beverages for special-needs students. Desk, chairs, computer with printer, telephone, locking file cabinets, eye wash station, soap and paper towel dispenser, privacy screen, clock, sphygmomanometer and appropriate sized cuffs, stethoscope, wheelchair, pure tone audiometer, oto/ophthalmascope, balance beam scale, portable first aid kits.

School nurses should discuss unique needs for health office space with the director of special education or student services, building principal, and district administrator. Wis. Admin. Code PI 11.27(e)(1) states "The facility shall meet all prescribed standards in the school building codes and shall be determined to be appropriate for the regular and exceptional needs of the children to be served and appropriate to implement the curriculum of the program area."

Wis. Admin. Code PI 8.01 requires schools to maintain safe and healthful facilities by complying with all regulations, state codes, orders of the Department of Industry, Labor and Human Relations (now regulated by the Department of Commerce), orders of the Department of Health and Social Services (now the Department of Health and Family Services), and all applicable local safety and health codes and regulations. Current state codes and federal regulations that apply to health and safety in school facilities include:

- Wis. Admin. Code ILHR 56.06-15 (exits, passageways, and enclosure of combustible material)
- Wis. Admin. Code ILHR 56.16 (sanitary facilities such as rest room fixtures and drinking fountains)
- Wis. Admin. Code ILHR 64.03, 64.04, and 64.07 (heating and ventilation requirements)
- Wis. Admin. Codes IND 19 and ILHR 56.17 (lighting requirements)
- Wis. Admin. Code ILHR 32.50 and 29 CFR part 1910.1030 (implementing the federal Occupational Safety and Health Administration standard to minimize employee exposure to blood-borne pathogens)
- Americans with Disabilities Act (ADA) Code of Federal Regulations (requiring an individual evacuation plan for a child when the child cannot follow the standard building evacuation)

Questions about Wisconsin building regulations and codes may be directed to the Wisconsin Department of Commerce. McKibben and DiPaolo (1997) and the Robert Wood Johnson Foundation's School-Based Health-Care Program offer more information about features and floor plans for basic and enhanced health-services offices.

Emergency Response Kits

School districts will want to carefully consider the content of emergency medical kits throughout the district and basic first-aid equipment and supplies in school health offices (see Figure 27 for some recommended items).

Appropriate equipment must be available to permit the rapid initiation of cardiopulmonary resuscitation (CPR), while providing required protection for the provider against infectious disease. Such equipment should, at the minimum, include:

- *Resuscitation mask*: one-way valve, adaptable to sizes, for mask-to-mouth ventilation.
- *Eye protection*: plastic glasses that prevent exposure to and injury from objects and body fluids which may fly about, particularly during urgent-care procedures.
- *Protective gloves*: latex-free, as many children with special health-care needs are allergic to latex due to repeated exposure during medical procedures. Gloves should also be impervious to viruses; some plastic gloves are not.
- *Suction device:* for rapid removal of mucus, vomit, and blood from the mouth and nose.
- *Thick pressure dressing*: sanitary gauze napkin or clean cloth to use as a pressure dressing to control hemorrhages.
- *Emergency notification tools*: notecards, pencil, whistle, walkie-talkie, or a phone (cordless, cellular, or digital) all come in handy in a variety of emergency situations.

In most cases, this equipment is effective, inexpensive, and compact. Ideally, it should be deployed alongside fire extinguishers within school buildings and should be provided in fanny packs issued to coaches, playground supervisors, event chaperones, and others responsible for children in more-isolated, potentially dangerous settings.

The district advisory panel that develops the emergency nursing plan may best determine the contents of the first aid kit. The size and complexity of a kit should be determined by

- the number of people to be served,
- likely medical problems, and
- the level of training of responders.

Particular consideration should be given to children with special health-care needs and to school events conducted in extreme temperatures.

Protocols

Written protocols are essential to the effective delivery of medical care, particularly emergency care. Responders need to know appropriate actions for given situations, the means of communication, and the chain of command for all that they do. Appropriate management of a medical emergency in any setting demands the following:

- *Maintenance of airway breathing and circulation*: While this may not be an issue when treating a scraped knee, it is crucial in managing a near-drowning in the school pool, a seizure in a classroom, or an accident with a power saw in the wood shop.
- *Prevention of further injury and safety assurance:* This may mean suspecting a neck injury in a diving accident, keeping an injured soccer player warm on a cold day, or placing a science student under the deluge shower after a chemical splash.
- *Timely institution of definitive care:* Medical care demands run the gamut from the trivial to the catastrophic. This spectrum of circumstances requires that responders be properly trained to provide timely, definitive care.

Effective management protocols should guide and empower staff members rather than make unreasonable demands on them and the facilities in which they work. When it fails at the former and “succeeds” in the latter, it fails in its primary purpose: ensuring the timely and effective provision of medical care for students. Protocols should take into account the wide variety of people who will be affected by them, including the local hospital and emergency medical service, students, parents, and those who may serve the district as volunteer service providers. Since many responders will not be highly trained professionals, written protocols should:

- consider symptoms, such as breathing difficulty or seizures, rather than diagnoses, such as asthma or epilepsy;
- allow for the severity of the condition, whether mild, moderate, severe, or critical;
- contain lay language rather than highly technical jargon or terminology (heart attack rather than myocardial infarction);
- detail clear and reasonable performance expectations as well as the level of training expected from those involved;
- be developed collaboratively involving persons affected by them; and
- be reviewed and signed by the medical advisor annually.

Communication

It is essential to establish clear lines of communication and to delegate responsibility so that

Figure 27

First Aid Equipment and Supplies

The following checklist of recommended First Aid Kit equipment and supplies is adapted with permission from materials prepared by the American Academy of Pediatrics.

- ☐ American Medical Association First Aid Manual
- ☐ American Academy of Pediatric Publications
- ☐ Disaster and Emergency Medical Services For Children
- ☐ Handbook of Acute Poisonings in Children
- ☐ First Aid Chart
- ☐ First Aid Treatment for Poisoning Chart
- ☐ Sterile dressings (sealed package), 2" x 2", for small wounds and eye pads
- ☐ Sterile dressings (sealed), 4" x 4", for large wounds and for compresses to stop bleeding.
- ☐ Sterile adhesive strips (sealed) in various sizes
- ☐ Roller bandage, 1" x 5 yds., for fingers
- ☐ Roller bandage, 2" x 5 yds., to secure dressings
- ☐ Adhesive tape, assorted widths
- ☐ Triangular bandages, for slings and as a covering over a large dressing
- ☐ Mild liquid antibacterial soap, for cleaning wounds, scratches, and cuts
- ☐ Sterilized, absorbent cotton
- ☐ Cotton swabs
- ☐ Tongue depressors, for the tongue as well as for splinting fingers, stirring solutions
- ☐ Splints, for arms and legs
- ☐ Scissors (blunt tip), to cut bandages/clothing
- ☐ Tweezers, to remove splinters or insect stingers
- ☐ Hot water bottle with cover
- ☐ Ice bag, to reduce pain and swelling
- ☐ Eye dropper and large syringe, to irrigate wounds
- ☐ Sterile saline, such as preservative-free contact lens solution, to rinse eyes and flush wounds
- ☐ Portable stretcher
- ☐ Blankets, sheets, pillows, pillow cases (disposable covers suitable)
- ☐ Cot and mattress with waterproof cover
- ☐ Covered waste receptacle with disposable liners
- ☐ Thermometer with disposable covers
- ☐ Safety pins
- ☐ Adjustable crutches
- ☐ Flashlight
- ☐ Airways
- ☐ Elastic bandages, 3", 4", and 6"
- ☐ Cervical collar
- ☐ Spine board with five-pound sand bags
- ☐ Foam blocks and tape, to stabilize the head, neck, and spine
- ☐ Cups (disposable paper), for drinking
- ☐ Gloves (plastic)
- ☐ Disposable tissues
- ☐ Barrier mask (one-way valve), for mask-to-mouth resuscitation
- ☐ Self-filling bags, valve, portable oxygen, with child- and adult-sized masks
- ☐ Oxygen cylinder and flow meter
- ☐ Manual (nonelectric) suction device, for clearing secretions
- ☐ Emergency tags
- ☐ Syringes and needles, for subcutaneous, intramuscular, and intravenous injections
- ☐ Antibacterial ointment
- ☐ Activated charcoal
- ☐ Aromatic Spirits of Ammonia (smelling salts)
- ☐ Acetaminophen preparations

a child in need receives optimal care. Critical paths of communication may include notifying

- staff members at or near a scene
- administrators
- the school nurse
- emergency medical technicians
- the child's physician
- the parent, guardian, or caretaker
- the district's physician adviser

Communication protocols should be developed which do not impede providing appropriate care. Prompt notification of key individuals or providers should be encouraged by whatever means possible, including:

- emergency cards
- messengers
- intercoms
- telephones (including cellular)
- walkie-talkies

Staff members should be trained and authorized to take definitive action such as notifying the EMS if they believe the situation warrants such a call. While notifying an administrator and/or parent during such an emergency is common and important, responders should consider the care of the student their top priority and not feel compelled to defer definitive care decisions while those people are being sought. Similarly, transport to a medical facility should not be delayed by efforts to locate and notify parents.

The district should inform parents ahead of time, perhaps through newsletters or registration packets including emergency information cards, of district policies regarding medical emergencies, and parental input should be sought when developing or revising such policies. This is particularly true in the case of children with special health-care needs.

Emergency Information Cards

As previously mentioned, emergency information cards (EICs) play a crucial role in providing medical care in the school setting. EICs should be a mandatory part of student registration; they should be completed by parents and returned to the district during the summer so that they're on file before the academic year begins. This timeline allows the school nurse time to plan for the acute and chronic health needs of its students, and it makes it easier to anticipate and prepare for possible emergency situations (such as might occur among students with diabetes or severe allergic reactions). Similarly, students enrolling later in the year should be required to provide an EIC as part of their registration.

It is recommended that the EIC contain

- the student's complete name, address, telephone number, age, and ethnic/racial background
- information regarding the student's parents, guardians, or caretakers, including work telephone numbers and custody arrangements
- medical information, including significant illnesses, allergies, and medications
- special health-care needs to be addressed while the child is at school, including medications to be given (Note: Children who require medication at school may be required to have written authorization from a parent and the prescribing physician.)
- the name, address, and telephone number of the child's physician(s) (Note: Written permission from the child's parent may be required to legally authorize communication between school staff and a physician.)

Severe Allergic Reactions

School districts should establish specific protocols for managing allergy emergencies. Severe allergic reactions, such as angioedema of the airway and anaphylactic shock, represent a special class of life-threatening emergency that requires immediate treatment with subcutaneous epinephrine. Automatic injectors—such as the EpiPen—are highly recommended, since they eliminate much of the cost and risk of error associated with other methods of epinephrine administration.

Districts will also want to consider whether they have epinephrine available wherever children are at risk for allergic reactions to food, drugs, plant, or insect exposure. Such sites might include the school building proper; cafeterias; the school bus; and outdoor areas used for athletic events, marching band activities, and science projects.

In addition, specific students and staff members known to have severe allergies should be encouraged to carry an appropriate personal supply of epinephrine and be trained in its proper use.

Furthermore, the district is well advised to consider the possibility of having a physician's standing order for epinephrine administration to anyone who demonstrates signs and symptoms of severe allergic reaction. This order may dictate that care providers consult with "medical control" (a local emergency room or physician, for example) before administering the epinephrine (see Figure 28).

Figure 28 ■

Sample Physician's Standing Order

Standing Order for an Allergic Reaction (Anaphylaxis)

A. Anaphylaxis is an allergic reaction that may be triggered by a food allergy, insect sting, or drug reaction. *If a person with a known history of severe allergic reaction is exposed to a known allergen, activate emergency medical services immediately. Do not wait for symptoms to develop!*

B. Assess the patient for symptoms of shock or respiratory distress.

1. Respirations: may be wheezy, labored, or absent
2. Pulse: may be rapid, weak, or difficult to detect
3. Color: may be pale, mottled, or cyanotic
4. Skin: may be cool, moist, or clammy; urticaria (hives) may be present; nailbed capillary refill time may exceed two seconds
5. Blood pressure: may be low or undetectable
6. Other: stupor, agitated, restless, vomiting, diarrhea, headache, unconsciousness

C. Monitor the airway, keeping it open. As needed, remove secretions/vomitus and assist with ventilation.

D. If patient is in shock and/or respiratory distress *and if no other specific physician order is available*, administer epinephrine as follows:

	Weight	Height	Administer
1. First dose:	<33 lbs. (15kg)	<39 in. (1m)	EpiPen Jr. (0.15 mg epinephrine)
	>33 lbs. (15kg)	>39 in. (1m)	EpiPen (0.3 mg epinephrine)

Note: Because 90 percent of girls and over 95 percent of boys five years of age and older weigh more than 33 pounds, the district may choose to stock only the EpiPen (0.3 mg epinephrine). In an allergy emergency, too much epinephrine would be far less dangerous than too little.

2. Subsequent injections may be given every 15-20 minutes, in accordance with observed symptoms (Section B above) or instructions from medical control, if available.

E. Supportive Care

1. Lie patient flat, facing up (supine position); raise feet 8 to 12 inches.
2. Keep patient warm, but not overheated.
3. Do not administer any solid or fluid by mouth.
4. If bee stinger is noted in skin, remove by gently scraping at skin level.
5. *Monitor patient closely, as sudden clinical deterioration can occur despite treatment.*

Source: Adapted from Brainerd, E., and J. Rosen. "Emergency Care and Anaphylaxis" Presentation at the School Health Leadership Training Conference, Atlanta, June 1997.

Child Alert 1033

Child Alert 1033 was developed to provide better EMS care to children with special health-care needs. At its best, Child Alert 1033 is a proactive service through which physicians and parents inform their local EMS of information that may be needed should EMS be called upon to provide emergency care to a particular child with special needs.

Physicians and parents initiate a Child Alert 1033 record that provides the EMS with a detailed summary of the child's medical problems and instructions for emergency management. This information, which should be regularly updated by the physician and parents, is then on file in all ambulances and at EMS headquarters. The school nurse is well-advised to coordinate with EMS student Child Alert 1033 information to facilitate timely and appropriate nursing care and EMS transportation. Through correspondence, school newsletters, and preregistration materials, school districts should ask parents/guardians of children with special health-care needs to notify the school if their child participates in the Child Alert 1033 program or if they are interested in learning more about the program. This improves communication and cooperation among health-care personnel and families of medically challenged children, improving care and reducing stress when a medical emergency occurs.

For information about Child Alert 1033, parents should contact their local school district or EMS. If a Child Alert 1033 program does not currently exist in your area, consider contacting your local hospital or Beloit Memorial Hospital (608/363-5800) or LaCrosse Lutheran Hospital (608/785-0530, ext. 3264) for more information.

Practice

Emergency medical care, such as CPR and first aid, cannot be learned adequately from books, posters, and/or videotapes alone. CPR and first aid skills must be learned through hands-on training and must be practiced periodically. Such skills are not difficult for most people to master and are absolutely essential to providing emergency care, as required by Standard (g). Courses in Basic Life Support and CPR can usually be arranged with the local chapter of the American Heart Association and the American Red Cross, respectively. It is recommended that the following people participate in such training:

- nurse and health aides
- teachers
- teacher's aides
- coaches
- crossing guards
- bus drivers
- custodians
- secretaries

Districts may also consider some sort of recognition program for staff members who—whether they agree or are obliged to take part in such training—are responsible to be trained as emergency responders.

Playback

Review and evaluation of the emergency nursing service is essential. One of the best ways to do this is through consistent use of incident report forms, which should completely and accurately provide a number of details, including the:

- student's/staff member's name and age
- date and time of the incident
- location of the incident
- nature of the medical problem
- body part injured
- description of the incident and injury
- body fluid exposure information
- further management or referral information (referred to physician, transported by EMS, parents notified, and so forth)

A review of this information as well as health management guidelines and/or protocols can provide valuable insights in assessing and, when necessary, improving emergency medical services, training, and communication provided by the district.

Furthermore, a regular review of the health service logs and incident report forms may reveal an emergency "hot spot" in the school, such as slippery steps, broken safety equipment, or damaged playground equipment. If not noticed earlier, such unanticipated causes may be identified and remedied to prevent further injury to others.

As always, such information may also prove helpful in justifying related staff and budget requests to the district administration and the school board, whether the purpose of the request is to maintain, enhance, or alter a program.

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Children with Special Health-Care Needs 10

Introduction

Children may have any number of special health-care needs that require attention during the school day. Appropriate assessment and coordinated health-care services in the educational setting are essential to allow children with special health-care needs to reach their potential and take their rightful place in society. As many school nurses and staff members have experienced, medical and other assistive technology advancements greatly enhance the quality of life and educational potentials of children with special health-care needs.

It is imperative that program development and services for children with special health-care needs be family-centered. This can be accomplished through collaborative efforts by teams representative of the school, family, and community in a manner consistent with federal, state, and local educational, health, and legal requirements.

Those involved in providing special care or services must also recognize that not all children with special health-care needs will require "special education" services. Many children will be served in regular programs under Section 504 of the Rehabilitation Act of 1973, with the guidance of a written individualized health plan (IHP).

The guidelines in this chapter are sensitive to the financial and human resource demands placed on school districts. It is important to note that the majority of children with special health-care needs can be served with existing school resources. To assist school districts in serving such children, this chapter focuses on:

- the educational need for special health-care services,
- legal considerations,
- program development,
- collaboration,
- policies and procedures,
- identification,
- related services,
- homebound instruction,
- equipment and supplies,
- problem resolution, and
- related resources.

Educational Need

The need to provide and constantly improve school health services to children with special health-care needs was documented in the 1990 *Study of Specialized Physical Health-Care Services in Wisconsin Public Schools*. According to that report, approximately 2.2 percent (17,224) of Wisconsin students receive some degree of specialized physical health-care services or service monitoring. The report also noted that 8.1 percent (6,737) of all children with disabilities receiving special education also receive specialized physical health-care services while in school.

In recent years, the philosophy of providing services to children with special health-care needs has changed to include:

- full family participation;
- shorter admissions to hospitals; and
- reintegration into the child's home, school, and community.

These philosophical changes have greatly influenced children and their families, professional health-care providers, and school personnel.

For example, student who sustains a traumatic brain injury or is diagnosed with cancer encounters a series of critical transitions during recovery and treatment. The student's discharge from the hospital or rehabilitation facility and return to home, school, and the community are pivotal transition processes. These transitions require detailed planning, coordination, and frequent communication between and among the student, parents, medical personnel, and school personnel. If all of these people are aware of the medical and educational pathways in these processes, everyone—especially the student—will benefit. The medical system and the educational system represent two aspects of a rehabilitation/treatment continuum for a student with a severe injury or chronic condition. A child's successful transition between them is more likely when health-care and school professionals are aware of what each system has to offer and the rules by which each operate.

Historically parents have been responsible for creating the bridge between these systems. It is understandable that parents experience significant emotional distress following their child's injury or diagnosed condition, may not have an adequate understanding of the educational process and available school programs, and may not be prepared to coordinate all the activities involved. Because of this, both the health-care and school personnel, including the school nurse, need to facilitate communications and develop a mutual commitment of responsibility to the child's success.

Each of these care providers will continually experience a need for adequate preparation in order to develop and effectively utilize systems that provide comprehensive community-based services. To meet these challenges safely, it is crucial that representatives from families, schools, and community agencies collaborate to identify and support programs that promote positive educational outcomes for children with special health-care needs.

Legal Considerations

A child having special health-care needs is defined in Wis. Stat. 253.02(a) as one who

- has health problems that require interventions beyond routine and basic care; *or*
- is at risk of having a disability, handicapping condition, health-related educational problem, and/or health-related behavioral problem.

The population of Wisconsin children with special health-care needs is quite diverse, influenced by such contributing factors as specific diagnosis, chronicity of the illness (including infectious illnesses), physical impairments, psychological conditions, ethnic background, sexual orientation, or acquired disability.

The legal requirements described in this chapter address nursing services for children with special health-care needs in the school system. (The reader is referred to Chapter 2 for the discussion of professional nursing practice.) Federal statutes and regulations as well as state statutes and administrative rules regulate school nursing services.

Federal Regulations

The federal statutes influencing the provision of care to children with special health-care needs include:

- the Individuals with Disabilities Education Act (Reauthorized 1997), formerly known as the Education of the Handicapped Act
- Section 504 of the Rehabilitation Act of 1973
- the Early Intervention Program for Infants and Toddlers with Disabilities (PL 99-457, 1986)
- the Americans with Disabilities Act of 1990

Individuals with Disabilities Education Act

The federal Individuals with Disabilities Education Act (IDEA), which was reauthorized in 1997, governs the education of children with disabilities. IDEA-R97 describes the responsibility of schools to provide a "free and appropriate education" (FAPE) to children with disabilities. FAPE includes special education and related services that

- are provided at public expense, under public supervision and direction, and without charge to the parents;
- meet Department of Public Instruction standards;
- include an appropriate preschool, elementary, or secondary school education in Wisconsin; and
- are provided in conformity with an Individualized Education Plan (IEP) designed to address each child's special education needs.

IDEA also contains requirements for the evaluation of a child suspected of having a disability and for the development of an IEP. The following definitions are also important for nurses and school staff members to know and understand as they care for children with special education needs:

- *Special education* is specially designed instruction at no cost to parents to meet the needs of a child with a disability. Special education may include instruction in the classroom, in the home, in hospitals and institutions, and in other settings. An IEP team must also consider supplementary aids and services to facilitate success in general education.
- *Related services* are those services which are necessary to assist a child with a disability to benefit from special education. The IDEA regulations specifically include school nursing or health services as related services.
- *Assistive technology device* is any item, piece of equipment, product, or product system which is used to increase, maintain, or improve the functional capabilities of a child with a disability. Such materials may be used "as is," modified, or customized to meet a child's particular needs.
- *Assistive technology services* assist children with disabilities in selecting, acquiring, or using assistive technology devices. Among others, the school nurse may provide assistive technology services.
- *Least restrictive environment* is the term used to define the proper setting for providing services to a child with a disability. The law requires that, to the maximum extent appropriate, districts educate students with disabilities alongside students without disabilities. This is an important principle for IEP teams to consider when developing IEPs. The team may remove the child from the general education setting only when teachers cannot educate them satisfactorily in the general classroom using supplementary aids and services. In nonacademic and extracurricular activities—such as meals, recess, clubs, athletics, and student employment opportunities—each child with a disability has the right to participate with children who do not have disabilities to the maximum extent appropriate to the needs of the child.
- *Transition services* are a coordinated set of activities designed within an outcome-oriented process that promotes movement from the school to post-school activities, such as postsecondary education. The activities must be based on the student's needs, taking into account the student's preferences and interests. The activities include instruction, related services, community experiences, the development of employment and other post-school adult living objectives, and, when appropriate, acquisition of daily living skills and functional vocational evaluation.

Due to the recent reauthorization of IDEA and enacted revisions to Wis. Stat. 115, the Wisconsin Department of Public Instruction is in the process of implementing the revised IDEA. Though there are a number of changes in IDEA-R97, those pertaining to related services have not changed. The DPI provides up-to-date information regarding implementation of the IDEA at its website at http://www.dpi.state.wi.us/dpi/dlsea/een

Section 504 of the Rehabilitation Act

Section 504 of the Rehabilitation Act of 1973 is designed to eliminate discrimination on the basis of disability or handicap in any program or activity receiving federal financial assistance (34 CFR sec. 104.1). School districts, cooperative educational services agencies, children with disabilities education boards, and the Wisconsin Department of Public Instruction receive federal funding and thus are required to meet the guidelines of the act.

Section 504 defines a handicapped person as "any person who has a physical or mental impairment which substantially limits one or more of the major life activities, has a record of such an impairment, or is regarded as having such an impairment" (34 CFR sec. 104.3(j)(1)).

The regulation defines physical or mental impairment as "(a) any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological; musculoskeletal; special sense organs; respiratory, including speech organs; cardiovascular; reproductive; digestive; genitourinary; hemic and lymphatic; skin; and endocrine; or (b) any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities" (34 CFR sec. 104.3(j)(2)(i)).

In order to avoid inadvertant exclusion of a particular condition, the definition does not specify diseases or conditions; however, examples given in federal interpretations of the regulation include orthopedic, visual, speech and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional illness, attention deficit disorder, drug addiction, and alcoholism. The impairment must substantially limit a major life activity, including caring for one's self, performing manual tasks, walking, seeing, hearing, breathing, learning, and working (34 CFR sec. 104.3(j)(2)(ii)).

Children in public schools who qualify as "handicapped persons" under Section 504 must have access, without discrimination, to public school programs and activities. In addition, Section 504 requires public schools to provide a free and appropriate public education (FAPE) to each qualified handicapped person who is in the school's jurisdiction. Section 504 defines "appropriate education" as the provision of general or special education or related aids and services that are designed to meet individual educational needs of handicapped persons as adequately as the needs of nonhandicapped persons are met.

Section 504 also requires schools to

- conduct an evaluation of a child believed to need special education or related services before placing the child in a general or special education program,
- educate handicapped persons with persons who are not handicapped to the maximum extent appropriate to the needs of the handicapped person, and
- establish and implement procedural safeguards.

Compliance with the procedures and requirements in IDEA is one way of meeting the requirements under Section 504. Many public school districts have identified a Section 504 coordinator to respond to Section 504 referrals. For additional information, contact the U.S. Department of Education, Office for Civil Rights–Region V, 111 North Canal Street, Chicago, IL 60606; (312) 886-8434 or (312) 353-2540 TDD.

Early Intervention Program for Infants and Toddlers with Disabilities

In 1986, Congress enacted Public Law 99-457, which added Part H to IDEA. Part H is a national program that assists states in establishing a statewide system of services for children under the age of three with developmental delays and their families.

In Wisconsin, the Department of Health and Family Services (DHFS) is the lead agency for the Birth to Three Program, the state program which implements Part H. DHFS has developed regulations (Wis. Adm. Code HSS 90) which govern the program.

National and state regulations governing Part H contain specific rights and procedural safeguards to protect children and their families, including provisions requiring that an Individualized Family Service Plan (IFSP) be developed and implemented in a voluntary, nondiscriminatory, and family-centered manner.

For more information on the Birth to Three Program, contact the Department of Health and Family Services, Division of Community Services, P.O. Box 7851, Madison, WI 53707; (608) 267-3270.

Americans with Disabilities Act

The Americans with Disabilities Act (ADA) of 1990 specifies that, as of January 26, 1992, public entities and public accommodations must ensure that individuals with disabilities have full access to and equal employment of all facilities, programs, goods, and services. The ADA extends many of the rights and duties defined by Section 504 to public accommodations such as restaurants, hotels, theaters, stores, doctor's offices, museums, private schools, and child care programs.

Wisconsin Regulations

The State of Wisconsin regulates the provision of services to children with special health-care needs primarily through four statutes.

- Sub. V of Chapter 115 ("Children with Special Education Needs") requires local education agencies to provide free, appropriate public education to children with disabilities.
- Wis. Stat. 46.56 ("Wisconsin's 1991 Children Come First Act") establishes a standard system which can be used to develop integrated systems of care; authorizes the key public educational and human service agencies to participate in collaborative systems; and provides direction for technical assistance and statewide coordination.
- Wis. Stat. 441 ("Wisconsin Nurse Practice Act") and Wis. Admin. Code N6 define the scope of nursing activities and the regulation of safe practice.
- Wis. Admin. Code HSS 61.30 ("Community Developmental Disabilities Services") establishes service standards for community developmental disabilities programs.

Wisconsin administrative rules are two-fold: Department of Public Instruction (PI 11) rules address nursing services as a part of special education and related services in schools; Board of Nursing (N6 and N7) rules regulate the practice of nursing, regardless of where in Wisconsin a registered nurse practices.

Registered nurses, physical therapists, occupational therapists, speech and language therapists, audiologists, and licensed practical nurses have specific areas of health-care practice for which they are responsible, defined by licensing laws and regulations. Professional practice requires that each of these licensed care providers accept responsibility for the care they legally and competently provide.

In accordance with these laws and regulations, the school nurse can identify and delegate to teachers, teacher aides, school health paraprofessionals, school secretaries, and volunteers certain specialized care procedures they can provide in the school setting. It is particularly important that school nurses follow all regulations, because school personnel who are not health-care professionals and who provide specialized care *must be delegated* this responsibility and be under the general or direct supervision of an appropriate licensed health-care professional.

The DPI provides up-to-date information regarding Wisconsin statutes and administrative rules at its website (http://www.dpi.state.wi.us/dpi/dlsea/een).

Program Development

The challenge of developing a program to provide services for children with health problems requires school personnel to first assess student needs and local resources. This guides and assists district staff in the delivery of comprehensive, coordinated, family-centered services. In order to provide quality care, the school district needs to create a climate that is responsive to the child and family needs, supportive to its staff, and organized in an efficient manner. This can be accomplished through collaborative relationships with other agencies to ensure that both the educational and health-care needs of children are met.

A team approach is most effective for planning, implementing, and evaluating programs for specialized health care. Existing school district committees or groups can be used to fulfill team concepts presented in this chapter. Initially, each district should establish a school health advisory committee, which has the task of assessing and documenting specialized health-care needs presented by students as well as the district's resources for providing specialized health-care services. The committee can then develop the program components of policies, resources, funding, procedures or protocols, and personnel requirements. Representatives from the school district and the community should comprise the council, including:

- school health-care professionals
- parents of children with special health-care needs
- district administrator(s)
- student-services representative(s)
- teachers
- health-care agency/community organization representative(s)
- nonprofessionals currently providing special health-care services

A number of other pubications/resources may prove helpful to those interested in program development and designing service-delivery models (Collins, 1992; Rapport, 1996; WDPI, 1992), including

- "Program Development Inventory" (see Appendix SS);
- "Enhancing Quality" (New England Serve, 1989).

Collaboration

When developing services for children with special health-care needs, it may quickly become apparent that the resources of individual agencies are insufficient to meet these special needs. Thus, the school team should address each student's needs carefully. In considering such issues as assessment, funding, and service delivery, the school team may determine that assistance is needed from a variety of sources, including:

- public and private health-care providers
- social service agencies
- philanthropic organizations

Technology has enabled children with complex health-care needs to be transferred from the hospital to the home and community. Integrating them into a school system can be a major step toward achieving to their potential.

Often, a skilled private duty nurse must accompany the child to school, creating a new set of roles and responsibilities for the child and the family, the private duty nurse, the school nurse, and other school staff. While the school is generally not required to provide a private duty nurse, it may be involved in assisting the family in securing this service.

Furthermore, the Wisconsin Board of Nursing (1992) recommends that "where there are nurses from different agencies, e.g. school nurses, public health nurses, and home health nurses providing care in the school setting, there should be contracts or protocols developed between the school districts and agencies which address the specific responsibilities of each nurse. It cannot be assumed that the school nurse has total accountability for all nursing care provided, if there are nurses from other agencies also providing care."

Policies and Procedures

School districts need to have policies and procedures in place that ensure children with special health-care needs can receive an appropriate education in a safe environment. A safe environment implies that these children will receive those health-care services necessary to maintain their health status so that they can benefit from their educational program. To maintain one's health status means to stay as healthy and functional as possible, to prevent deterioration in one's condition, and to support one's ability to develop normally. The responsibility and accountability for decision making related to those services provided by the school should be clearly defined in the district's policies for children with special health-care needs.

The following principles provide a sound basis for developing policies and procedures in schools or other settings where educational services are being provided and are applicable to all children under age 21 who are entering or are in school programs (SCDE, 1992):

> "Every child with a disability is entitled to a free, appropriate public education and related services in the least restrictive environment. Again, as mandated by IDEA (R97), each district is required to develop and implement for such students an individual education plan, or, as mandated by Section 504 of the Rehabilitation Act of 1973, an accommodation plan."

It requires collaborative decision making among parents, students, appropriate administrators, school nurses, teachers, and other school staff members. Lines of decision making, responsibility, and communication must be clearly identified within the organizational structure. Additional information on the decision-making process is available (Rapport, 1996; SCDE, 1992; WDPI, 1992).

The current health status and health needs of children with identified or potential special health-care needs, whether they are related to physical or mental health, should be assessed. The school nurse is one of a few professional health-care providers in the school setting qualified to complete this assessment. Determining the health status and health needs of children with known health impairments that are psychological in nature may require collaborative assessment by the nurse, school social worker, school psychologist, or other mental health professionals.

When a child requires specialized health care in school, the school nurse, in conjunction with the parent/guardian, the child's health-care providers, and the child (when appropriate), develops an individualized health plan (IHP) based on a comprehensive nursing assessment. When circumstances make it appropriate, the school administrator, school nurse, school medical advisor, classroom teacher, and other pupil personnel specialists participate in developing the IHP. Who is consulted or informed will depend on the age, grade level, health condition, developmental needs, and confidentiality needs of the student; the personnel available; lines of administrative and clinical decision making; and the type of service provided.

Whenever a child needs health-care services or monitoring by school personnel other than the school nurse, a planning meeting must be scheduled. The planning meeting should include the family, the school nurse, the school administrator, school personnel who will be responsible for monitoring the child's needs or providing specific services, transportation personnel, and community health-care providers, as appropriate. At the meeting, school adaptations and/or accommodations necessary for implementing the child's IHP and IHP details should be reduced to writing and clearly communicated to the child's parents or guardian. The IHP should delineate

- the child's health-care needs and related adaptations required in school;
- responsibilities for service delivery;
- training needs of and other resources required by personnel to implement the plan;
- designation of a school case manager; and
- the frequency of review and evaluation of the plan.

If there is a reason to believe that a child has a disability, the nurse should refer the child for an evaluation to determine eligibility for special education programs and assistance. If the child is eligible for services, either under IDEA-R97 or Section 504, it may be appropriate to incorporate the IHP into the IEP or accommodation plan.

The district should consider, plan, and arrange for the following in a timely manner:

- the type of personnel qualified to provide necessary care and services;
- appropriate training, supervision, and/or consultation for staff;
- safe and appropriate transportation;
- supplies and equipment necessary for the school to provide health services to the child; and
- a safe learning environment.

In addition, the district may wish to include information regarding the above-mentioned services in the student's IEP.

As with other students, those with special health-care needs should also meet all other general health and immunization requirements mandated by the district or state.

When the administration or supervision of special health-care procedures or treatments in school requires a physician's order and parent authorization, both the detailed order or prescription and the parent's permission must be received in writing before the procedure or treatment can be administered in school.

Health-care services in school must be provided in a manner consistent with national, state, and local standards for health-care services and professional practice. Specialized health-care procedures must be adapted to the needs of the individual child and should be performed by qualified personnel.

When licensed professionals delegate selected procedures to other personnel, the licensed professional remains responsible for supervision of those individuals carrying out the procedures and for the quality of care provided (Wis. Admin. Code N6.03).

To whatever degree possible, the delivery of health care to a child should minimize disruption to the educational process of other children. Education, school health, and transportation personnel may require continuing education, clinical consultation, and/or child-specific training to ensure they are equipped to effectively deliver services which will help minimize educational disruptions.

In addition, districts must develop infection-control policies and procedures in accordance with current public health standards and regulations of the Occupational Safety and Health Administration to ensure a safe educational environment for students and staff members.

Districts should also make resources available to the personnel who are providing school health services for children with special health-care needs.

Furthermore, the district must do everything in its power to ensure that the child's and family's right to confidentiality and privacy are protected. School personnel are responsible for maintaining such confidentiality, except when it is necessary to share information about the health status of a child for the protection of the child, of other children, or of school personnel. When confidentiality is an issue, consultation with the parent, school medical advisor, school nurse/nursing supervisor, and the primary-care physician is advisable. (Record systems and confidentiality are discussed in greater detail in Chapter 11.)

Policies and procedures regarding school health records must be maintained consistent with

- state and federal education laws;
- state and federal confidentiality laws;
- state and federal health laws; and
- standards of practice for nursing and medicine.

With respect to these legal factors, districts may need to develop, review, update, and revise policies and procedures related to the education of children with special health-care needs. These policies and procedures may relate, but not be limited, to:

- the organizational structure (decision making)
- personnel
- the evaluation and placement process
- instructional programs
- essential resources
- staff development
- records and confidentiality
- infection control
- equipment maintenance
- transportation
- child identification
- notice on Section 504
- funding for services
- appeals (in other words, conflicts with principal or physician recommendations)
- homebound services
- "as necessary" or "standing" orders from physicians
- responding to "Do Not Resuscitate" orders (see Appendix TT)
- interagency agreements (for children with their own health-care providers)

Sample policies can be obtained from the Wisconsin Association of School Boards, 122 West Washington Avenue, Madison, WI 53707-2718. Additional resources may prove helpful (AFT, 1992; Collins, 1992; Sirvis et al., 1989; WDPI, 1998).

Identification

Identifying children with special health-care needs often occurs years before a child enters the public school setting. With some children, however, special health-care needs will become more apparent when the child enters a preschool or public school setting. In such cases, a plethora of assessment and health-care-related information may have already been obtained by the child's private and public health-care practitioners and can be made available to the public school system. It is critical that health-care information is held confidential by all school personnel. This information may assist staff members in determining whether a child should be referred for

- assessment for a possible disability required under IDEA,
- special accommodations required under Section 504, and/or
- specialized health-service support for which they are not eligible under IDEA or Section 504 (for example, nursing care for an acute situation such as a fractured bone).

Public education services are required for all children, including those with special health-care needs. The entry of a child with special health-care needs into the school setting presents a challenge to the family, school staff, and community. A collaborative effort by all is needed to assess, plan, implement, and accomplish a safe, healthy, and educationally sound program.

Districts may wish to incorporate a health assessment or physical examination along with immunization compliance as an entry requirement for all children. A health assessment is intended to ensure that children with chronic or significant health conditions are assessed for special needs and that health-care providers communicate those needs to school health personnel. Those people can then plan for appropriate school modifications, services, or monitoring. The review of a health assessment is within the scope of responsibilities of the school nurse.

All districts have student entrance requirements and procedures, including the completion of enrollment forms. Such forms should require detailed health information, which is the most common source of information from parents to schools regarding a student's health-care problems and needs. When parents inform the school of health concerns that might interfere with the educational process, the principal or other administrator—working with the school nurse—should proactively review that information and decide if a follow-up is necessary to discuss special education services, Section 504 accommodations, or regular education services.

If follow-up is indicated, a team approach is generally viewed as the most effective model for assessing, planning, implementing, and evaluating the delivery of care. The team should include the people directly involved in the child's education and care, such as school and community health-care professionals, parents or guardians, teachers, paraprofessionals, the child, and appropriate school administrators. An organized planning and decision-making process is necessary for a child's smooth transition into the education setting. To ensure this, the team must be thoroughly familiar with the evaluation and placement process required by state and federal laws.

The role of the school nurse, as defined by the Wisconsin Nurse Practice Act and the ANA and NASN standards of school nursing practice, is to

- assess the health and developmental needs of the child and respond to parental and staff concerns;
- access available pertinent medical data;
- attend school team meetings, presenting findings, recommendations, and strategies that respond to students' special health-care and education needs;
- educate staff as to the nature and relevance of the health condition;
- determine with the school team how to meet students' needs;
- develop and implement an IHP for students, as needed;
- as appropriate and necessary, delegate, train, monitor, and supervise nonprofessional school health personnel performing nursing duties; and
- monitor and evaluate the ongoing health status both of students and health services.

Modifying School Programs

When appropriate, the regular education program should be modified to meet the student's needs. Examples of modifications that may need to be considered include:

- transportation
- building accessibility
- medications and other special health-care services
- stamina (that is, the need for rest periods)
- positioning
- self-help skills

- assistive equipment, technology, or supplies
- privacy
- specially prepared curriculum materials
- modified or adapted physical education, art, music, or other classes and activities
- mobility and need for assistance, including building evacuation
- field trips and extracurricular activities
- meals and snacks
- hospital and/or home instruction

Responding to Referrals

Once the team determines that a student needs special health-care services, a number of possible steps can be taken.

Parents should complete the:

- "Parent Request for Special Health-Care Procedure" (Appendix UU), and the
- "Request for Physician's Order for Special Health-Care Services Performed at School" and "Authorization for Exchange of Information" (Appendix VV).

The school nurse should:

- obtain the physician's (or primary health-care provider's) written orders, including the "standardized procedure" from the approved guidelines for providing the service, for the district or affected agency;
- obtain and summarize pertinent information concerning the student's health-care needs; and
- develop an Individualized Health Plan (see Figure 25).

If a parent files a "Do Not Resuscitate" (DNR or "no code") order for their child, the district should carefully follow all district policies and procedures.

Developing and Implementing the IHP

Under school nurse standards of practice, including the Wisconsin Nurse Practice Act, the registered nurse develops an individualized health plan (IHP) for children with special health-care needs who require nursing services during the school day. The IHP is a detailed, written plan developed through a collaborative process among the child (when appropriate), the child's family, the child's family physician, other school staff, and community health-care providers. The plan may take one of several forms: a nursing-care plan, an emergency-care plan, or an integrated plan accompanied by an individualized education plan (IEP)/accommodation plan or an Individualized Family Service Plan (IFSP).

The IHP describes nursing interventions appropriate to the child's condition and contains student data and needs at a particular point in time. Haas (1993) relates that IHPs should reflect the "best practices" of school nurses as they interact daily with students, families, educators, and other members of the medical community. An IHP must be specific enough to describe what will be done in terms of time, frequency, and location, duration; what results are expected; and what parameters are important to monitor. The organizing framework includes assessment, nursing diagnosis, goals, interventions, and student outcomes.

The plan of care can be used to formulate IEP\IFSP objectives; to create an emergency plan; or to make recommendations about staffing needs and the potential delegation, training, and supervision of all nonprofessional school health personnel involved in the student's care. Students who qualify for special education services on the basis of a related health need or 'other health impairment' may need an IHP. (Note: Chapter 8 contains further discussion of the IHP; sample IHPs can be found in Chauvin, 1994; Collins, 1992; and Haas, 1993.)

IHPs and the Special Education Process

Individualized health-care plans are frequently associated with the special education process; however, this is not their only purpose. Any child with a relatively complex health condition or a need for modification of the school environment due to a health condition should have an IHP.

When participating in the special education IEP process, school nurses need a method to describe the relationship between a student's health needs and educational process. Preparing an IHP is an important step which should be completed prior to an IEP meeting. School psychologists prepare reports on test scores, and occupational and physical therapists document their assessments based on testing. School nurses should use the IHP as a first step toward formulating special education or accommodation recommendations and student goals. Whenever possible, sections of the IHP should be incorporated into the IEP during the special education process.

Interdisciplinary teams can use IHPs as they assess the needs of the special education or 504 child. In these situations, the school nurse obtains parent/guardian permission to assess the child. After reviews of the child's health history and medical records, discussions with the student and family, and gathering current health and developmental assessment data, the school nurse summarizes the data and develops a list of recommendations based on the child's health and learning needs. This report should be shared with the special education or accommodation team, and planning phase is carried out by the entire special education or school team. It is advisable to document nursing-care needs and services on the child's IEP as "related services." This becomes particularly important when accessing Medicaid funding for children with disabilities who qualify for special education.

Children who are not special education-eligible may also need an IHP (see Chapter 8). For example, children with chronic illnesses usually require some additional monitoring or modifications in their educational program. The formation of an IHP helps ensure that all necessary information, needs, and plans are considered to maximize the child's participation and performance in the school setting.

Emergency-Care Plans

Emergency-care plans may be a component of an IHP as well. Emergency-care plans are usually procedural guidelines indicating who to call and other useful information in the event that a predictable emergency occurs. For example, a child with seizures may need a specific medication or transportation to a medical facility if the medication is ineffective. Emergency-care plans usually do not give sufficient information to meet all of the child's health needs but may provide valuable procedural guidance to nonprofessional school health personnel or teachers working with a particular student when a life-threatening incident occurs. Children with these types of conditions will benefit from both an emergency-care plan and an IHP. The IHP would then cover other aspects of their care, such as a child's knowledge about his/her condition, self-care abilities, and any modifications needed during the school day to enhance learning or to prevent emergencies if possible.

Related Services

Related services are those services which may be required to assist a child with a disability in benefitting from special education. Related services may include:

- counseling
- early identification and assessment
- parent counseling and training
- recreation
- rehabilitation counseling
- transportation
- audiology
- psychology
- physical therapy
- occupational therapy
- school health
- school nursing
- school social work
- medical diagnostics or evaluations

Many children with disabilities will have multiple educational and medical needs that may be intertwined and may require special health-care services which could or could not fall within the scope of school health services.

For example, these children may require some of the following services during the school day: gastrostomy care; nasogastric, parenteral or intravenous feeding; tracheal suctioning; continuous monitoring of respirator status, in addition to the more common health services delivered within the school environment (e.g., medication administration, catheterization, nebulizer treatments, blood glucose monitoring, and skin care). As such, these health-related services and procedures are necessary for a child with special health-care needs to benefit from the education program and may be provided as related services.

Rapport (1996) identifies numerous court cases which provide some direction, however, each ruling is child specific and, therefore, difficult to generalize and establish clear guidelines for school districts. The ability to separate medical services from school health services has been a long-standing problem and continues to cause conflict today, as in the situations where multiple or extensive health-care procedures are required frequently or continuously throughout the school day. In these situations the school nurse and child's physicians will need to discuss and carefully consider the child's health needs. School districts must look carefully at the case law within their own jurisdiction to clarify where the judicial system currently stands on this issue. Ultimately, the IEP team will need to make an individualized determination as to whether needed service is a related service and therefore should be included in the child's IEP.

Homebound Instruction

School nurses and districts will find themselves regularly dealing with two types of students needing homebound instruction: special education students with disabilities and regular education students without disabilities.

Special Education

Special education students with disabilities may be more likely to require homebound instruction. Such a decision should be made by the IEP team only after receiving a written statement from a physician that the student is not able to attend school due to a disability.

Wis. Admin. Code PI 11.31(1) provides for special education and related services for students with disabilities in the home, hospital, sanitarium, or convalescent facility.

Further information on homebound instruction for students with disabilities is available in DPI Information Update Bulletin 92.9, "Special Education Homebound Instruction: Residency, Procedures for Provision, and Programming Services."

Regular Education

Occasionally, nondisabled children develop special health-care needs (for example, temporary health conditions, exacerbation of a chronic illness, or pregnancy) that require homebound instruction. Technically, students can be excused from school for up to 30 days at the request of a parent/guardian if the student is not in proper physical or mental condition to attend. In such cases, schools may request that the parent/guardian provide a written statement from a licensed physician, dentist, chiropractor, optometrist, or Christian Science practitioner as proof that the condition exists (Wis. Stat. 118.15(3)).

When such conditions are documented and homebound services are determined to be appropriate, it is recommended that districts provide the affected student with homebound instruction. Decisions to provide homebound instruction to regular education students must be made on a student-by-student basis, as the health of some students may not allow for such instruction, while the health of others would allow them to benefit from such instruction. Similarly, decisions regarding the amount of time which will be devoted to a student's homebound instruction program should be made based on the student's physical, emotional, and educational needs.

While direct daily instruction is highly recommended for every student, technological advances make it possible to enhance that instruction with a variety of support equipment, including:

- telephone conference calls
- audiotapes
- videotapes
- closed circuit TV hook-ups
- correspondence courses
- films
- computer connections via modem

As is the case with homebound instruction for disabled students, the provision of regular education homebound instruction to a nondisabled student must be guided by a written plan, which should be included in the student's education records.

Equipment and Supplies

Just as it is difficult to establish general guidelines regarding the provision of related services to disabled children, it is difficult to offer guidelines regarding the provision of equipment and supplies. However, the Office of Special Education Programs (OSEP) has provided some guidance in this area which will assist schools.

Generally, OSEP has held that a district is not required to provide an assistive technology device or service to a disabled student if the student also requires that device or service when not attending school. OSEP adds that this exclusion does not apply in situations in which a district determines that a disabled student requires an assistive device or service in order to receive a free, appropriate public education *and* specifies that the device or service is part of the student's special education program, a related service, or a supplementary aid or service.

In addition, 1994 USDA Food and Nutrition Services (FNS) Instruction 783-2 (Rev. 2):

- requires substitutions (such as special diets or formulas) to standard meals for participants who are considered handicapped and whose handicap restricts their diet; and
- permits substitutions for other participants who are not handicapped but who are unable to consume regular program meals because of medical or other special dietary needs.

Problem Resolution

To resolve conflicts or problems that may arise under the provision of health services as related services under IDEA-R97, parents have three formal avenues for problem resolution. Informal discussion, proceeding up the chain of command, should be attempted first, with appropriate corresponding documentation and advocacy support. The special education laws provide for three methods of formal conflict resolution: mediation, requesting a due-process hearing, and filing a complaint with the Department of Public Instruction.

The least formal approach to resolving conflicts is through mediation. Mediation is facilitated negotiation in which a neutral and impartial third party (a mediator) helps parties resolve their disputes in a private setting. The mediator does not impose a decision on the parties, but rather assists the parties to identify issues, generate options, and create their own solutions. Any agreement reached in mediation is binding on the parties. Conflicts that may be appropriate for mediation include: conflicts concerning identification, evaluation, educational placement of a child with special education needs, or the provision of an appropriate special education program to such a child. The DPI Information Bulletin 97.9, entitled "Special Education Mediation System-Implementation Plan," provides guidelines for parents and school districts interested in mediation.

The second option is to request a due-process hearing to resolve the conflict. A due-process hearing is initiated when a parent or a school district sends a letter of request for a hearing to the Department of Public Instruction. The letter must state the specific reasons for the request. When parents file a request for a hearing, the request also should include the child's name and residence address and the name of the school district; a description of the problem leading to the hearing request and related facts; and, to the extent known, a proposed resolution of the problem. An impartial hearing officer will conduct the hearing and issue a final decision within 45 days of the request for a hearing. The hearing officer's decision is final and binding unless appealed in state circuit court within 45 days of the date it was mailed or in federal district court. Both the complaint and due-process hearing procedures are described in detail in the Department of Public Instruction's *EEN Triangle of Support: A Guide for Parents*.

The third option available to resolve conflicts is to file an IDEA complaint. Any individual or organization may file an IDEA complaint with the Department of Public Instruction if they believe a school district has violated a state or federal law or regulation relative to programs for students with disabilities. All complaints must be in writing and must be signed. The complaint should state that the school district violated the law and the facts upon which the allegation is based. Complaints may be made to: Assistant Superintendent, Division for Learning Support: Equity and Advocacy, Department of Public Instruction, PO Box 7841, Madison, WI 53707-7841.

Complaints under Section 504 of the Rehabilitation Act of 1973 and under federal regulations adopted under this Act (34 CFR 100.7) may be filed with the Office for Civil Rights. This complaint alleges that an individual child or class of individuals has been subjected to discrimination on the basis of disability. The complaint must be made within 180 days of the alleged discrimination under Section 504 of the Rehabilitation Act of 1973. Complaints can be made to: Office for Civil Rights-Region V, 111 North Canal Street, Chicago, IL 60606; (312) 886-8343 or (312) 353-2546 TDD.

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Administrative Issues

11

"If we could first know where we are
and whither we are tending,
we could then better judge what to do
and how to do it."
Abraham Lincoln

Introduction

Schools are vital members of the community. Their educational missions and goals focus on producing educated and healthy citizens who are equipped to make a meaningful contribution to the greater community. Now more than ever, schools are responsible for providing health education and school health services, both independently and in concert with agencies and institutions based in their communities. Because the health of the school community has a direct effect on the greater community—whether it is through the spread of disease or information or as a result of the schools' success (or failure) at returning to the community students effectively educated regarding common and far-reaching personal, family, and community health issues—building systems that engender cooperation and partnership among and between partners in community health is critical.

General Principles

Many schools, parents, health and human service agencies, churches, nonprofit volunteer organizations, businesses, and local governments are realizing that by working together they can design strategies that respond to local conditions more effectively and use community resources more efficiently. These partnerships design comprehensive strategies to bring together a range of resources– education, health, mental health, child care, social, and recreational services–to strengthen families and promote the healthy physical, social, emotional, and cognitive development of children.

Comprehensive school health service programs are integral to the educational mission because they provide centralized access to an array of health programs which support and enhance student readiness and learning. Comprehensive strategies reach well beyond the school doors and invite broader and more far-reaching endeavors. Principles of these comprehensive strategies are clearly stated in a 1996 U.S. Department of Education publication entitled *Putting the Pieces Together*; they include:

- helping children, parents, and families by building community resources and relationships;
- helping children, parents, and families solve immediate problems and develop the capacity to avoid future crises;
- building working relationships among the community's major groups and cultures, including parents, a range of agencies and organizations, and churches;
- involving multiple partners within and outside the school in all stages of program planning, design, implementation and evaluation;
- communicating in languages that are accessible to all partners; and
- flowing from a shared vision and responsibility for improving long-term conditions for children,

families, and communities—not simply a goal of providing services or treating a problem.

Children and their families benefit from comprehensive strategies on many levels: they get help facing immediate challenges, learn lifelong methods for improving their own circumstances, gain access to a range of services, and become better able to participate in their own learning. They become more ready and able to learn, and they benefit from learning experiences.

Teachers, principals; school counselors, social workers, and psychologists; and other school staff as well as nurses benefit from comprehensive strategies. Everyday these practitioners and administrators observe the barriers to student learning brought on by hunger, lack of medical care, inadequate child care, poverty, adolescent pregnancy, violence, and other social conditions. Through comprehensive strategies, school staff gain allies they can turn to both inside and outside the school to help address these challenges. Comprehensive strategies can change the school atmosphere and the way teachers feel about teaching; indeed, teachers are reassured to know that they are not alone in working with children and families to prevent, remove, or modify barriers to learning (U.S. Department of Education, 1996).

Comprehensive strategies are vitally important when establishing and maintaining effective school health-services programs. These strategies naturally involve the broader community, so that the programs reflect community needs, values, and resources; prevent duplication of effort; and provide systems of leadership that endorse systematic rather than categorical approaches to student education, disease prevention, and health promotion.

When school health-services program planning, development, and evaluation engender the principles underlying comprehensive strategies, the benefits for the school health-services program and the broader population it serves can include:

- school and community education and health objectives compatible with national objectives;
- an action plan to achieve school education and health objectives;
- a prioritized, coordinated, and connected (with community members) effort to achieve school education and health objectives;
- benchmarks for measuring success in achieving school education and health objectives;
- tangible results that improve school and community health;
- tangible results that document the contributions of school health personnel to school and community leaders and legislative bodies;
- uniform data for valid comparison of local and state health data; and
- an organization/cadre of committed citizens who will work actively toward the achievement of school health and education objectives.

This chapter will help school nurses, school administrators, and other collaborative partners

- review federal and state laws, regulations and rules, and local school district policy that address school health-services program issues.
- review the school district's organizational structure, function, and processes and the school health-services program mission, vision, purpose, and processes.
- assess one's own knowledge of comprehensive school health-services programming; develop a professional growth plan to address areas of need and identify accessible resources such as continuing education; regional, state, and national agencies; published materials; and networks with colleagues.
- in cooperation with administration, the school health advisory committee, other school personnel, and community agencies and organizations, provide leadership to develop, implement, and evaluate a comprehensive school health-services program that
  - interprets the health needs of children in the school setting
  - prevents, modifies, and removes health-related barriers to learning
  - establishes organizational structures that provide clinical supervision and consultation
  - fosters mutual commitment to and responsibility for improving student readiness and conditions for learning
  - develops information, management, and service systems that monitor trends and inform policy development
  - invites collaborative research related to student health and education outcomes

To that end, the chapter describes important administrative issues that contribute to developing an effective comprehensive school health-services program. Such a program focuses on the developmental needs and health-risk factors of the school-aged population, takes into account the diverse needs of students and adults in the school and community setting, involves those affected by the program, engages qualified trained staff to deliver services, and employs multiple methods and strategies to address identified needs.

Establishing an effective school health-services program helps students get the most from their education by providing a safe, caring, and healthful environment. Administering a program requires that attention be given to

- a school and community health needs assessment
- a planning and implementation process
- program evaluation
- policy development
- record systems
- confidentiality and access
- funding
- liability
- school nurse performance evaluation
- collaboration

School and Community Needs Assessments

Many schools recognize that good planning seeks to develop an accurate assessment of need in partnership with the community. Given the complexities of program planning and development on this scale, it is important for school districts to assess their internal organizational capacity to carry out such efforts. Many good ideas are not implemented because of limited administrative support for carrying out a needs assessment and program planning in schools. Assessment of a school district for the purpose of school health-services program planning should address:

- legal considerations
- community relations
- policy development
- existing availability of school health or community health services
- staffing patterns
- information and program management systems
- financial management

Once a school district has conducted an assessment of its organizational capacity, it may wish to develop a plan to build on its internal strengths, overcome its challenges, and enhance its organizational effectiveness for carrying out districtwide efforts. No school district has all the resources to comprehensively address the problems at hand. Working in partnership with school personnel and community members can provide synergy–a sense that "we are all in this together"–and begins to build the constituency necessary to successfully carry out a plan or program.

School Health Advisory Committee

School districts are well-advised to establish a school health advisory committee to carry out and review needs-assessment data, to monitor the effectiveness of the school health-services program, and to provide recommendations for program development and improvement. Such a committee's responsibilities include:

- assisting in developing a school and/or community health needs assessment that identifies student health needs;
- reviewing state and federal requirements related to comprehensive school health programming;
- reviewing, providing input for, and recommending approval of school health-services program guidelines in areas like environmental health, health appraisal, communicable disease control, emergency nursing services, health education, and local interpretation of the Wisconsin Framework for Comprehensive School Health Programs;
- reviewing, providing input for, and recommending approval of guidelines for implementing school health-services program goals, objectives, policies, and procedures regarding personnel, facilities, and supplies;
- advocating to improve the health status of children, adolescents, and families in the community;
- recommending resources for a comprehensive school health-services program; and
- participating in the evaluation of school health-services and other comprehensive school health programs.

Membership of the school health advisory committee should be broad and reflect representation from parents, students, school staff, school administration, student-services providers, health educators, public health personnel, private and community-based health-care providers, local government agencies, volunteers interested in school health, and members of the clergy and business community.

Assessing Need

Regardless of the assessment and planning framework used (and many exist), it is important to examine three dimensions of the school-community: population, location, and social system. Each dimension alone and in combination with the others will provide data with which to plan, deliver, and evaluate health education and service programs for school-aged children and youth.

Population

The makeup and profile of the population of school-age children and youth is a major determinant of the actual and potential problems and needs that will emerge in the assessment process. In an assessment, the overall goal is to relate the profile of school-age children and youth to the profile of the broader population in the community. This will help identify both needs and resources. A brief description of the general population can provide a context for developing the assessment. This might include the size of the population, recent growth or decline in the size (or of particular age groups) of the population, ethnic or racial data, family income, employment statistics, school-attendance characteristics, and health characteristics.

Location

While the location in which school-age children live can assist in locating and securing needed resources, it can also provide a challenge in obtaining needed services. When considering location, data gathering may include identifying communities within the boundary of the school district; the location of educational, health, and social resources and services; geography; housing; and natural and human-made features of the environment.

Social System

Every community has a social system, the many parts of which are linked and interdependent. The breakdown of any one of these parts can and does influence the community social system. When considering this dimension, one should examine a variety of factors that may be perceived as strengths, challenges, or barriers, including those related to health; social services and family support; day care, preschool, primary, or secondary education; economics; religion; politics; recreation; legal; and communication.

Knowing how a community interacts will help identify the sources of actual or potential problems. For example, does the distance from health facilities limit or deny services to specific people or groups of people? Does a lack of preschool programs for chronically ill children hinder future attainment of educational goals for those children and respite goals for their families?

A variety of approaches can be taken to conducting school health needs assessments. Depending on local resources, some schools may choose to focus on one of the approaches that follow, while others may choose to blend them. It is important for school districts to select those that will provide the data with which to plan, deliver, and evaluate health education and health-services programs for children and youth (or for subpopulations such as early childhood, children with disabilities, or at-risk youth) in the district. Regardless of the assessment approach used, only valid data (quantitative *and* qualitative) analyzed with significant input from school and community leaders will lead to a successful, dynamic program.

Three comprehensive approaches to program planning include a needs-assessment component:

- *School Health Needs Assessment*, available from Health Services Center at the University of Colorado Office of School Health in Denver
- *School Nurses: Strengthening Comprehensive School Health Programs for Adolescents*, available from the Educational Development Center in Newton, Massachusetts
- "Assessment Protocol for Excellence in Public Health," available from the National Association of County Health Officers, 440 1st Street, NW, Suite 500, Washington, DC 20001, (202) 783-5550

Much of the methodology described in these assessment processes and protocols can be readily applied to local schools. (See Chapter 13 for contact information for these and other assessment and planning resources.) The information that follows discusses several useful approaches to gathering data during the needs-assessment process.

Community Forum

This approach uses school-community forums to collect assessment data. School districts may wish to tap school health advisory committee members to help develop the structure of the needs assessment and gather information at open communitywide meetings. Key questions are addressed at the meetings either in large or small groups. Responses are tabulated and high priority needs are developed and disseminated. Among the advantages to this approach are the ease of data collection, the low cost, and community involvement. Disadvantages include difficulties in securing a representative sample of the community; control of the meetings by persons with specific points of view, unrealistic expectations of forum participants, and highly subjective and nonrepresentative data that may result (Spiegel and Hyman, 1987).

Community Inventory

A community inventory focuses on examining the social systems in the community. The intent is to determine the roles and responsibilities of these systems in the community, the perceptions of the people affected by health-service delivery and those who deliver health services, and the relationship between/among systems (for example, public health and its relationship to schools in the district). This approach can result in a more thorough school and community assessment, creating a comprehensive picture of the school-community and its needs (Spradley, 1990).

Key Communicators

Key communicators are people who know their school and community and are willing (or eager) to talk to outsiders about them **(Green, 1982).** The key communicator approach is a research method of obtaining data about specific populations or about the community in general. It is a process that entails assembling a group of people who are representative; can generate a questionnaire and analyze the results; and can come to consensus regarding the high-priority needs facing the population or the community under study. Among the advantages to this approach are its low cost, the ease of collecting broad-based data, and the involvement of individuals to assist in program development and systems building. Chief disadvantages include individual biases and a lack of complete knowledge of community systems (Spiegel and Hyman, 1987).

Nominal Group

This approach is a "structured meeting which seeks to provide an orderly procedure obtaining qualitative information from target groups who are most closely associated with the problem" (Del Becq, Gustafson, and Van de Ven, 1975). A simplification of the steps includes: generation of key questions for the team, rapid generation of ideas, clarification of statements, and voting. This approach encourages each member of the group to participate, encourages the generation of minority opinions, alleviates "hidden agendas," facilitates team work, and focuses on identifying rather than solving the problem (Logan and Dawkins, 1986; Witkin and Altschuld, 1995).

Problem-Oriented Assessment

This approach begins with the identification of a single problem (for example, how to address the needs of at-risk youth) and then assesses the school and community in terms of that problem. It may include determining the incidence and prevalence of at-risk behaviors in the school, community, or state as a whole; interviewing "key communicators" in the school and community; and determining both needed and available resources. Such an assessment is a useful alternative to more expensive and time-intensive approaches (Spradley, 1990).

Survey

A survey focuses on drawing a representative sample of the school and community populations and then analyzing data generated from the sample. If the principles of sampling are adhered to, this approach can provide valid and reliable data on population or community needs. Survey processes include: defining the objectives of an assessment; securing interdisciplinary connections; designing the survey tool; identifying the sample population; collecting data through interviews, telephone calls, or direct mailings; analyzing the data; and presenting the findings and recommendations. Advantages of this flexible approach include gathering more valid and reliable data; obtaining direct information from sample populations; and addressing a wide variety of needs and issues. Among its disadvantages are its cost and the lack of cooperation by some survey participants, both of which can affect the quality of the data. It also requires experience and training in sampling techniques and questionnaire design (Spiegel and Hyman, 1987).

A Case Study

A school district in southeastern Wisconsin was experiencing many of the early- childhood problems common in many districts. Young children were entering kindergarten without basic learning-readiness skills, with undiagnosed health problems, and without the benefits of nurturing home environments. The problems were well known to staff, administrators, and student-services providers in the community, but publicly received only periodic anecdotal comment.

The school superintendent, gauging common concern, convened a task force to discuss and articulate the issues surrounding early childhood education. Since the problems expanded beyond the school, the effort from the entire community was viewed as necessary to initiate intervention. Key individuals and representatives from community organizations were encouraged to participate, and flyers and press releases encouraged parental involvement. The broad-based community recruitment resulted in a sizable task force that included a number of school staff, school board members, public health officials, social service agency representatives, parents, extension service providers, health-care providers, and other interested community residents.

The task force developed a mission to ensure that children entering school had the physical, emotional, social, intellectual, and imaginative skills necessary for academic achievement and a lifetime of positive growth development. It adopted a method of assessing early school readiness that focused on school performance indicators of need: child development, health considerations, parent involvement in early learning and social and emotional development, educational opportunities such as Head Start, and family demographics.

Through the school district's leadership, a broad-based school and community group was assembled with a common interest and focus. The size and diversity of the group brought multiple levels of expertise to the process and a capacity to develop an assessment tool, collect and analyze the data, and prepare everything necessary to initiate a planned intervention effort. The probability of success was high because many of the partners asked to participate in the assessment and helped to articulate the problem; they also became partners in providing the services needed to accomplish the resulting planned interventions.

Program Planning and Development

School nurses generally serve more than one school and need to make efficient and effective use of their time; accomplishing that aim depends on carefully applying management processes and principles. In addition to having a working knowledge of the critical-thinking process, nurses serving schools need a working knowledge of management theory and process. Both of these systematic processes are essential in planning, delivering, and evaluating nursing care for students and adults in the school setting. In short, management entails accomplishing school health-services program goals within the context of the district mission, vision, and goals through the coordination of human and material resources.

Because the management process provides a rational approach to defining the health needs of the school population, developing and implementing plans to meet those needs, and meaningfully evaluating program outcomes, the management process is critical for school nurses to understand and consistently use within school health programs. While it is beyond the scope of this guide to provide in-depth information about management for school nurses; recent nursing literature has highlighted the essentials of management for nurses. In addition, many baccalaureate and graduate nursing programs now have courses and study programs in management. Thus, the opportunities for school nurses to increase their knowledge and skills in management and leadership are available through local colleges, universities, and professional organizations.

Program planning may begin after the school-community needs assessment is completed and the findings shared and discussed with the school health advisory committee and the public. Based on the needs-assessment results, analysis and interpretation of the data, and a shared vision of the school health-services program that has emerged within the context of school district and community priorities, school nurses can play an important leadership role by initiating program planning.

During the planning phase, school nurses cooperating with the school health advisory committee explore options that flow from the common concerns that emerged through the needs-assessment process. They agree to focus on specific needs; design a delivery system that incorporates the elements of the shared vision; identify target outcomes; and conduct an in-depth analysis of their leadership, assets, needs, and existing resources (assuming they were not analyzed prior to conducting the needs assessment). The nurse working with the committee may also develop technical tools or strategies needed to put their plan into action. It is not uncommon for the school health advisory committee to bring in other or new partners and to continue building ownership for the school health program.

The current school health service delivery system may be simple or complex (see Figure 29, "Types of School Health Programming"). Members of the school health advisory committee must understand how each part of the school health-services program or even a single program component can affect the school system and community programs. They must be able to identify when and why problems occur and what changes need to be made. This is most successful when the committee focuses its efforts at the point at which the program comes into contact with children, their families, and school staff. By examining the entire program as it affects the schooling process and by creating a plan to improve service delivery in a specific area, the committee is more likely to learn the lessons necessary to affect long-term change within the school health-services program.

The plan to improve service delivery in a specific target area can help the school health advisory committee assess and document the needs of children, their families, and district staff as well as barriers to obtaining school health and other services. The plan also provides an opportunity for partners to experiment with interagency agreements and policy changes to make health services more accessible. Additionally, the plan enables the school nurse and members of the school health advisory committee to test the fit between areas in need of improvement and the realities of implementation. Learning from experience, the school nurse, committee members, and other partners can adapt the plan's most successful elements to other areas or school health-services programs.

If children' health status improves and they are better able to participate in their learning as a result of the school health-services program, how will we know? What will they be achieving? What might indicate that achievement is or is not occurring? The answers to these questions become the outcomes to be monitored and the measures to be used.

A school health-services program should do more than simply deliver a specified number or variety of services. Instead, it must enable children to better participate in their learning and improve their health status in clear and measurable ways. Working with the school health advisory committee, the school nurse needs a clear idea of the intended outcomes and measurable methods for achieving them.

During this phase of the planning process, the school nurse and the school health advisory committee revisit the priority areas that emerged during the school and community assessment and select the ones identified as priorities in the service delivery design. The committee also identifies the desired behavioral outcomes of students, staff, and health-services programs. Indicators of improvement might include student and staff behavior and school policies that result in health promotion, service delivery built on family strengths, flexibility and responsiveness to a range of family situations, and efficient interaction among school staff and community health personnel on behalf of students.

The indicators should state clearly the degree of improvement expected within a specific period of time. Because the school nurse and the advisory committee are accountable for attaining measurable outcomes, the outcomes should be reasonable, should relate to available data, and should occur over a sufficient period of time.

To achieve these outcomes, the school nurse, the school health advisory committee, and other partners will need to carefully evaluate policies, practices, processes, personnel, and environments. Consideration should be given to providing the management, services, and information systems necessary to support the school health-services program including: the number of students in the target population, the types of interventions or services planned, the anticipated number of interventions, integration with health education curriculum, standards of practice related to planned interventions, the type and number of school health staff, location of services/program, equipment and supplies, school district and other agency/organization policies, and ways to fund the school health-services program.

The school nurse and the school health advisory committee will need to bear in mind that the purpose of a single program component or an entire school health-services program, in addition to providing quality services to targeted students, is to gather information about how to foster systemwide school and community change that enables children to better participate in their learning and supports improved health and education outcomes.

An effective school health-services design will identify student needs, barriers to service, and ways school and community partners can work together to reduce those barriers for all children and their families—not just those in the target population. They will need to ask, "What mechanisms currently exist or must be developed to help us collect and use information more effectively?"

Interagency case management is an important strategy used in many school health-services designs. At the service delivery level, interagency case management can help students with multiple needs benefit from available education and health services. At the systems level, it provides important information on how well the existing services meet students' needs and highlights areas need-

Figure 29

Types of School Health Programming

Programs	Purpose/Service	Target Audience
School-Based Student Health Centers	Personal health services (primary care) delivered in schools: health history, physical exam, treatment of acute illness, mental health counseling, management of stable chronic disease, and lab work. Emphasis: clinical health services	Individual students of all ages in need of primary care
Comprehensive School Health	Disease prevention and health promotion programs for students: health service, education, environmental health, food service, counseling and psychological services, and physical education	All students, all grades
Nursing Services	Population-based primary health-care services: screening, referral, and follow-up; case management; complex nursing care to students in need; case management; health teaching; immunization surveillance; and communicable disease control	All students
Special Education	Health services for children/youth with special health-care needs eligible for related services	Students with/without academic impairments whose health conditions interfere with their right to a free and appropriate education
Student Assistance Programs	Primary prevention measures for substance abuse, violence, truancy, and pregnancy; improve student academic performance; modeled after employee assistance programs (EAPs)	All students
Comprehensive Integrated Services	Integrated primary, secondary, tertiary services for children and youth, one-stop shopping for health and human services and education to enhance student well-being.	All students, with special attention to high risk youth, available to both individuals and groups

Constituency	Providers	Funding Source
Communitywide support, representing parent and student groups and health, education, and social services representatives	Nurse practitioners Physicians Clinical social workers Counselors Health educators Health educators	Title V agencies/State health Medicaid Managed-care organizations Private foundations
Centers for Disease Control, Division of Adolescent and School Health American School Health Association Other school health-related membership organizations	Teachers Registered professional school nurses Counselors Food service personnel Physical education staff	Centers for Disease Control, Division of Adolescent and School Health
Parent and Teacher Associations National Nurses Coalition for School Health Other school health-related membership organizations	School nurses School personnel School health assistants supervised by school nurses	School and community health funds including Title V State and local education funds for related health services
Parents Special education groups Advocacy organizations for physically challenged or mentally impaired students	Physician consultants Registered professional school nurses Speech pathologists and audiologists Occupational therapists Physical therapists Psychologists Specialist teachers	Individuals with Disabilities Education Act (IDEA-R97).
Counselors Parents Teachers Advocacy organizations for the prevention of substance abuse Registered professional school nurses	Teachers School administrators Guidance staff School health personnel Community resources	Safe and Drug-Free Schools and Communities Act of 1986 State and local funding from
Health, human services, and education agencies in communities embracing collaboration	School administrators Teachers Social workers Counselors Community representatives from recreation, law enforcement, and volunteer organizations Nurses and physicians	special legislation, regulations Private foundations

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ing change. School staff should help design the case-management process. Communicating the process is both important and necessary to ensure that teachers and other school personnel have a role in implementing case management and that the goals and objectives of the program design are reflected at all levels within the school. To ensure that case-management activities provide useful information during the evaluation phase, it is important for data collection about such activities to include clear notes on which services were not used and why as well as what barriers prevented students and their families from receiving services.

The school nurse and the advisory committee also need to ask what other strategies or tools are needed to reduce barriers to efficient and effective school health-services delivery. For example, developing common interagency assessments or eligibility-determination forms may save students and their families the burden of repeated questioning, may speed service delivery, and may save agencies both staff time and financial resources.

The school nurse and school health advisory committee should also consider implementing a management information system sufficient to store individual and aggregate data and program information. An effective management information system will permit the tracking and retrieval of accountability-related data on structure, process, and outcome information. This allows the school nurse and the school health advisory committee to analyze information, identify problems, and track progress toward key performance indicators of improved child health status and school achievement established during the planning phase. (An example of a general health-services program information summary tool can be found in Appendix WW.)

Once the school nurse, the advisory committee, and other collaborative partners design the school health-services program, they must develop an action plan for implementing the design. This plan will guide those responsible for implementation, serve as a document to secure approval of resources, and provide a program description that can be share with the school and the community. As part of the plan, partners must negotiate and formalize agreements among themselves to address a range of issues, such as priority service arrangements, the reassignment of personnel, and governance arrangements (see Appendix XX for a sample interagency agreement).

Program Evaluation

Program evaluation is an important process for a number of reasons. The evaluation process helps determine whether agreed-on goals were achieved. It helps determine if the achievements had the anticipated impact on the identified health problem or need. It also helps determine whether or not factors contributing to the health problem or need have been resolved or mitigated. Further, it informs program planning efforts.

Input Evaluation

Input evaluation focuses on the various elements that go into the operation of a program (for example, staff, participants, program resources, and support services). The purpose is to identify the elements and assess how well they support program objectives. Questions include, "Do school health staff have the necessary educational background, skills, and training to carry out the program?" "Are policies and guidelines in place to support program implementation?" and "Is there adequate equipment and supplies to deliver the school health-services program?"

Process Evaluation

Process evaluation monitors what the school health-services program is doing. Process evaluations have informal and formal measurements. Informal evaluations come from day-to-day program operations. At weekly meetings, all school personnel at all levels can assess health program operations. Feedback forms from school staff and students can contribute to this type of measurement.

To conduct a more formal evaluation, the school nurse and school health advisory committee need to clearly define the services and activities the program will provide to whom, when, where, and how. A management information system must be developed or in place which will permit the retrieval of data to determine whether performance indicators were achieved. Process evaluations seek to answer questions at the service delivery and systems levels. Some relevant questions at the service delivery level include:

- Are the services reaching the intended student population?
- What services are students receiving that they did not receive before?
- How has the service delivery changed?

- Has service delivery changed the relationship between students, their families, school staff, and/or partner agencies/organizations?

At the systems level, relevant questions include:

- How are the school health program's management and information structures working?
- Are school staff members and other partners upholding interagency agreements, sharing resources, and implementing the school health program as designed?
- Are school staff members and community health partners identifying and addressing system level barriers and challenges?
- What other changes within the school or across partner agencies has the health-services program produced?

School staff can obtain data for a process evaluation from student records; service logs; referral forms; cost breakdowns; descriptive program histories; and interviews with students, their families, school staff, and community health and social service providers. All gather information about students and their families and the health, education, and/or social services provided them. They also communicate between and among themselves. While the performance data do not speak to the quality or effectiveness of school health services provided, they do chart progress and contribute to program credibility and accountability.

Outcome Evaluation

Outcome evaluation can occur at two levels: the individual student level and the group level. Determining student-level outcomes involves questions about how the target population is different after the delivery of services. At its most basic, the question is, "What difference did the program make?" This type of evaluation provides a systematic approach to the collection of data about the achievement of individual service goals. Such data may be used to summarize both individual student and group education and health outcomes.

On the other hand, group level outcome evaluation is designed to determine the overall effect of the program on a group of students or staff members. This approach to outcome evaluation involves collecting data from different participants in the program. This data is then combined to determine the degree to which the group as a whole responded to the program and its services.

The program planning phase identified key indicators or outcomes targeted for improvement. Measuring change in the outcomes is done by comparing measures prior to program implementation with measures taken at intervals during the intervention and at the program's completion. Such information communicates how students are doing after they receive services and is usually sufficient to establish accountability and possible correlation between a service and an outcome.

Often, however, more sophisticated evaluation procedures are necessary to show that service patterns resulted in the change. These procedures are usually costly and may raise sampling and measurement problems. Most school health-services programs will need technical assistance to develop an evaluation design that balances cost, time, and methodological considerations. While the technologies and data needed to measure improved student-readiness and health-status results may only exist in part in the school setting, partnering with colleges, universities, and other research and evaluation services may foster a design for more effective evaluations.

Policy Development

Even though school boards are subject to multiple levels of statutory control, they have broad latitude for formulating policy. A number of policy-making models exist that take into account such factors as cost and political realities. While both of these are important considerations, the logical starting place is a model that recognizes legal and other constraints yet remains focused on objective outcomes. The legal constraints that must be considered exist within the U.S. Constitution and federal statutes, Wisconsin constitution and state statutes, state government agency administrative codes, professional guidelines and standards, local community ordinances, and school district policies. (Appendix H contains a list of statutes relating to the delivery of school health services and school policy topic areas; Appendix YY contains a list of policy topic areas.)

Policy is the voice of the local school board. It speaks when the school board is not convened and cannot address an issue directly. The aim of a constructive policy is to advance the school system in a steady path toward the attainment of its vision. Through policy, the school board sets goals for the entire school system and provides direction for administrators and other school staff members to follow while working toward achieving goals that support the mission and vision of the school district and reflect the context of the community being served. Effective school boards pursue five key stages of policy development that are both dynamic and interactive: identifying issues, setting priorities, analyzing and studying issues or trends, taking action, and following through to assess the effect of the decision over time.

Progressive school boards view the policy development process as an educational process and recognize that the policy-making process may be as important as the policy itself. The National Association of State Boards of Education (Bogden, 1996) outlines the valuable contributions of collaborative policy development.

- *Leadership:* the process enables school boards to demonstrate the importance of knowledge, principle, and experience to the making of sound policy.
- *Engaging the public:* a good process for developing policy takes into consideration all expressed points of view.
- *Guidance:* policies based on current scientific, medical, educational, and legal information clarify issues and lay out options for action; they anticipate potentially difficult situations and reduce chances of haphazard responses in urgent situations when written in clear language understandable to the general public.
- *Reassurance:* students, parents, and school employees need to know that safety and health are important concerns of school authorities and that concerns will be handled in a systematic, professional way.
- *Support:* to practice their professions with confidence, administrators, teachers, nurses, other student-services providers and school staff members need policy to back them up.
- *Awareness and understanding:* the policy-development process can increase people's knowledge about the facts, the complexity of issues, and the laws that shape schools' actions.
- *Accountability:* policies typically state who is responsible for doing what.
- *Legal protection:* sound policy helps to prevent activity that may be grounds for legal action; their adoption demonstrates good faith effort, which also helps protect the school district from lawsuits.

What precisely are policies? Policies are statements of principle that the school board adopts to outline a course of action. They tell what is wanted and often indicate rationale and how what is wanted will occur. In general, policies should give administration clear guidance, yet be broad enough to allow discretion in meeting the day-to-day concerns that arise (WASB, 1995).

The National Association of State Boards of Education (Bogden, 1996) outlines important steps when developing school health policies. Appendix ZZ illustrates suggested steps for policy development relating to HIV, considering whether to place HIV issues into existing policies for health, safety, communicable disease, attendance, special education, and others, because those policies are reviewed and periodically updated or to develop a specific HIV policy to address community and school staff concerns and to respond directly to people's anxieties. Each step addresses a key element; when combined with other steps, it equals the sum of a comprehensive policy that can be useful in most situations.

Record Systems and Confidentiality

Documentation is critical to developing and maintaining quality school health services. It is essential to the practice of professional nursing and is a fundamental component of the nursing process. Changes in society, in contemporary school nursing practice, and in the nature of school health services have resulted in an increased demand for expert management and delivery of health services in the school setting. Consequently, school nurses require methods of documentation and recordkeeping consistent with federal and state statutes and evolving nursing practice.

While safe and accountable school nursing practice requires adherence to the nursing process (assessment, diagnosis, planning, intervention, and evaluation) and systematic, continuous documentation of care provided to a student or staff member, traditional methods of documentation in schools are not always consistent with state and national standards of nursing practice. Additionally, few even well-developed school health record systems address the documentation requirements of students with complex health-care needs or the sensitive and private health issues of students and families that may not be appropriate in education records.

Documentation is the written record of the nursing process used to deliver care to students and is required by standards of professional nursing practice (Wis. Admin. Code N7; Schwab, 1992; ANA, 1983). The following are among the key considerations for school nurses addressing the issues of record systems and confidentiality:

- Know applicable state and federal laws and regulations and district policies that address pupil and patient health-care records in the school setting.
- Research the information needs and practices of the school, public health, and human services settings.
- Review school district policies and procedures; develop, as needed and in cooperation with administrators and other school staff, policies and procedures that
  - ensure appropriate confidentiality of pupil records, including patient health-care records, and decrease the barriers to releasing health information within and outside of the school setting.
  - identify who the record custodian of pupil records and patient health-care records is in the school district/building.
  - identify which categories of records are maintained, where they are located, and who has access to them (with informed consent and without informed consent)
  - identify call-back procedures for telephone inquires and address nonredisclosure of health information received from health-care providers
- Create, in cooperation with administration, a record system that ensures appropriate release of—and support of professional judgment concerning the release or nonrelease of—some or all components of pupil records.
- Clarify issues related to pupil records, including patient health-care records, between schools, local health departments, health and social service agencies, and other local health providers through a memorandum of understanding or other method.
- Secure technical and consultative resources, in cooperation with administration, from local legal counsel, appropriate professional networks, the state departments of Public Instruction and Health and Family Services, and published documents.
- Describe how school staff will be oriented and receive ongoing training and access to resources to ensure confidentiality and the appropriate handling of pupil records, including patient health-care records.

Documentation

School health records document the nursing services rendered. They make it possible to determine those nursing services provided to individual students or staff and groups of students or staff, the successful and unsuccessful outcomes of nursing and student or staff interventions, needed changes in the configuration of nursing services and school health programs, and any expected costs or savings of implementing recommended changes. Schwab (1992) notes that the documentation of school nursing practice is essential to:

- application of the nursing process to student or staff care
- communication
- demonstration of compliance with nursing standards
- quality assurance/risk management
- research in school nursing practice
- systems management
- third-party reimbursement

Application

Documentation is essential to the application of all phases of the nursing process, particularly the assessment and evaluation phases. According to Potter and Perry (1985), nurses cannot plan appropriate interventions for students or staff unless sufficient data are collected and interpreted to reveal relevant problems and resources. Each observation of a student or staff member's physiological, emotional, social, and intellectual functioning is part of a larger picture that reveals an individual's health status. Since an individual's or group's health status is not static, the ongoing collection of relevant data is critical. Continual review of data in light of new information is also essential to the formulation of accurate nursing diagnoses. An intervention and care plan for a student or staff member, based on sound nursing assessment and diagnosis, can only be evaluated for its efficacy over time if it is accurately documented and available for review.

Communication

Documentation provides a method for improving care and services and for communicating with students, families, health-care providers, school personnel, and student nurses. Record systems are a part of the communication and information structures of school districts. Schools establish and maintain a variety of educational and health records that are essential for documenting and reporting the educational progress of school-age children and youth. They constitute a legal record that describes the types of programs, services, and actions taken in support of children's and young learning. These records communicate with other professional health-care providers, to nonprofessional school health personnel, and to other staff when students move within or between schools, school districts, or states.

In general–and because the school is a nontraditional health-care setting–nurses cannot share certain school health records with school personnel in the same fashion that an interdisciplinary hospital team can share a common medical record. However, school health records provide an essential source of health information about a student and can be shared with the student, the family, emergency personnel, health-care providers to whom the nurse makes a referral for assessment and intervention, and school personnel involved in the child's care at school.

It is critical that school nurses have access to medical information about a child because nursing and medical documentation provide data relevant to the student's educational progress.. The nurse has a professional obligation to secure, review, summarize, interpret, and report information that physicians, physician assistants, and nurse practitioners provide.

Nurses must use professional judgment in determining how much information is relevant to a child's educational program. For example, when a child's health condition is stable or uncomplicated (as may be the case which some children with chronic health conditions), the nurse may only need to check periodically with the child's parents or health-care provider to update health information. However, if a child is experiencing frequent or unpredictable changes in a health condition or requires complex modifications of nursing procedures, the nurse will need to communicate directly with the child's physician. In such a case, the nurse must be able to access information about possible contraindications to treatment as well as the child's current health status.

Additionally, school nursing-services records, both clinical and program management, are an excellent source of data to evaluate the school health program and its various components as well as providing educational material for student nurses who receive clinical practice in a school setting.

Compliance with Nursing Standards

Documentation provides legally acceptable written proof of care as well as quality of care that a school nurse renders. In cases of professional negligence, nursing documentation may be the only evidence available to indicate whether an acceptable standard of care was met. In legal actions against school nurses, inadequate documentation of care is generally synonymous with inadequate or poor quality care (Northrop and Kelly, 1987). While documentation is not the only legally acceptable proof of care provided, it remains a critically important one.

Quality Assurance/Risk Management

Documentation provides accountability. Written records can be reviewed to determine whether the care provided met the nursing standards of care. School nurse supervisors use documentation to evaluate the competency of school health personnel providing direct care to students and managing the school health program. Of equal importance, written records enable the school nurse to continuously evaluate the care administered and demonstrate that outcomes are being achieved.

Research

Documentation of nursing services provided to individual students or groups affords a rich basis for research in school nursing practice. Research is necessary to determine the validity of specific nursing interventions in the school setting, to establish credible nursing services and school health programs, and to identify legitimate improvements in school nursing practice. Clear, concise, accurate, and timely documentation provides the foundation necessary for such scientific inquiry.

Systems Management

Data derived from direct and indirect school nursing services can provide a school health program, a school district, an external public or private health-care agency, or a hospital with information essential for efficient and effective management of the school health-services program. However, it is important that data management and information systems be based on methods of documentation that are time saving, clearly defined, easily retrievable in formats amenable to different uses, relevant to the operation of the program, and meet the letter *and* spirit of the law.

Third-Party Reimbursement

Documentation is an essential component of third-party reimbursement mechanisms. Data regarding student-specific nursing assessments, diagnoses, interventions, and outcomes will be necessary in order for nurses to obtain third-party reimbursement for the services they provide in the school setting.

Legal Considerations

While the Standards of Nursing Practice in Wisconsin (Wis. Admin. Code N7), Standards of School Nursing Practice (ANA, 1983; Proctor, Lordi, and Zaiger, 1993), and other related nursing profession standards are clear regarding a school nurse's documentation responsibilities. Applying these standards in the school setting can be complex. As a result, school nurses are frequently faced with conflicts between laws relating to education and laws relating to health-care. In order to appreciate this complexity, it is necessary to understand federal and state laws that describe the content, access, level of confidentiality, and retention requirements for school health records as well as the requirements set forth in local school district policies.

A description follows of the different types of legal records described in federal and state statutes and suggestions and considerations related to confidentiality, documentation, and development of records systems in the school setting. The summary of statutes are meant to be explanatory and do not represent a legal interpretation of state laws. It is essential that nurses and other health-care providers who work in schools cooperate with district administrators and student-services directors as they seek legal counsel regarding any interpretation of statutes, which are continually updated and modified. The state Department of Public Instruction recognizes that these suggestions and considerations alone will not solve many of the conflicts related to nursing documentation in schools. It hopes, however, that they will stimulate broad professional and community interest in examining and improving policies that pertain to the health records and record systems in school districts across the state.

Federal Laws

The primary federal law influencing record systems and confidentiality in public schools is the Family Educational Rights and Privacy Act (FERPA) of 1974. Additional federal requirements concerning records retention are contained in the General Education Provisions Act (GEPA) of 1978. Statutes relating to the education records of children with disabilities appear in the revised Individuals with Disabilities Education Act (IDEA-R97.

The fundamental requirement of FERPA is that every school district that receives federal funds for any program must publish a records policy and annually notify parents and students over 18 years of age about the policy. It affords parents and eligible students certain rights with respect to the student's education records. A list of parent and student rights follows.

- *The right to inspect and review the student's education records within 45 days of the day the school district receives a request for access.* Parents and eligible students should submit to the school principal (or appropriate school official) a written request that identifies the record(s) they wish to inspect. The principal will make arrangements for access and notify the parent or eligible student of the time and place where the records may be inspected.
- *The right to request amendment of the student's education records that the parent or eligible student believes are inaccurate or misleading.* Parents or eligible students may ask the school district to amend a record that they believe is inaccurate or misleading. They should write the school principal, clearly identifying the part of the record they want changed and specifying why it is inaccurate or misleading. If the district decides not to amend the record as requested, the district must notify the parents or eligible students of the decision and advise them of their right to a hearing regarding the request for amendment. Additional information regarding the hearing procedures will be provided to the parents or eligible students when notified of the right to a hearing.
- *The right to consent to disclosure of personally identifiable information contained in the student's education records, except to the extent that FERPA authorizes disclosure without consent.* One exception which permits disclosure without consent is disclosures to school officials with legitimate educational interests. A school official is a person employed by the district as an administrator, supervisor, instructor, or support staff member (including health or medical staff and law enforcement personnel); a person serving on the school board; a person or company with whom the district has contracted to perform a special task (such as an attorney, auditor, medical consultant, or therapist); or a parent or student serving on an official committee (such as a disciplinary or griev-

ance committee) or assisting another school official in performing assigned tasks. A school official has a legitimate educational interest if the official needs to review an education record in order to fulfill a professional responsibility.

Upon request and without consent, the district discloses education records to officials of another school district in which a student seeks or intends to enroll; the district also discloses directory data without consent. Directory data are education records which include the student's name, address, telephone listing, date and place of birth, dates of attendance, major field of study, participation in officially recognized activities and sports, weight and height of members of athletic teams, photographs, degrees and awards received, and the name of the school most recently attended.

- *The right to file a complaint with the U. S. Department of Education concerning alleged failures by a district to comply with the requirements of FERPA.* The name and address of the office that administers FERPA is: Family Policy Compliance Office, U.S. Department of Education, 400 Maryland Avenue, SW, Washington, DC 20202-4605.

In state law, the requirements relating to all pupil records are located in Wis. Stat. 118.125; requirements pertaining to children with disabilities appear in Wis. Admin. Code PI 11.37; and requirements relating to patient health-care information other than basic health information found in pupil physical health records are found in Wis. Stat. 146.81-84. These statutory provisions are interdependent, and it is important that both health and education professionals understand the law in total.

State Laws

A number of state statutes–all within Wis. Stat. 118–relate to the content of pupil records.

Pupil Records

Wis. Stat. 118.125(1)(d) defines pupil records as all records maintained by the school relating to students. These records may be maintained in any way, including but not limited to paper copy, computer storage media, video and audiotape, film, microfilm, or microfiche. Records maintained for personal use by a nurse, teacher, and others holding a license under Wis. Stat. 115.28(7) and not available to others and records available to persons involved in the psychological treatment of a child are not pupil records.

Behavioral Records

Wis. Stat. 118.125(1)(a) describes the content of behavioral records. These records include psychological tests, personality evaluations, records of conversations, any written statements relating specifically to an individual pupil's behavior, tests relating to achievement or measurement of ability, pupil physical health records (other than immunization records), any lead-screening records required by Wis. Stat. 254.162, law enforcement officers' records obtained under Wis. stats. 48.369(1) or 938.396(1m), and any other pupil records that are not progress records.

Directory Data

Wis. Stat. 118.125(1)(b) describes the content of directory data. Such data include the child's name, address, telephone listing, date and place of birth, dates of attendance, major fields of study, participation in officially recognized activities and sports, weight and height of members of athletic teams, photographs, degrees and awards received, and the name of the school most recently attended.

Progress Records

Wis. Stat. 118.125(1)(c) describes the content of progress records. This type of record includes the child's grades, statement of courses taken, attendance record, immunization record, any lead-screening records required under Wis. Stat. 254.162, and records of the student's extracurricular activities.

Pupil Physical Health Records

Wis. Stat. 118.125(1)(cm) describes the content of pupil physical health records. These records include basic health information about a child and are subject to the requirements governing behavioral records. Pupil physical health records include immunization records; an emergency medical card; a log of first aid and medication administered to the child, an athletic permit card; a record concerning the child's ability to participate in an educational program; any lead-screening records; results of any routine screening tests (such as for hearing, vision, or scoliosis) and any follow up to such tests; and any other basic health information, as determined by the state superintendent of public instruction. Basic health information includes a log of first aid or emergency nursing services provided under the authority of the school district, though it does not include records that contain such information as individualized health-care plans and supporting nursing documentation, diagnoses, opinions, and judgments concerning the child's health.

Confidentiality and Access

The issue of confidentiality has profound implications not only for the release of specific types of information but also for the relationship between schools and the students and families they serve.

Wis. Stat. 118.125(2) requires school boards to adopt regulations which maintain the confidentiality of all pupil records. Guidance is provided in this statute as to the types of circumstances under which students, parents or legal guardians, and others can have access to pupil records. Those situations in which pupil records (except information from patient health-care records) can be released without obtaining prior written consent include but are not limited to:

- persons employed by the school district who are required by the Department of Public Instruction under Wis. Stat. 115.28(7) to hold a license; other school district officials who have been determined by the school board to have legitimate educational interests, including safety interests, in those records; and those employees of the school district who have been designated by the school board to receive that information for the purpose of providing treatment programs.
- upon written notice from the student, parent, or another other school or school district that the pupil has enrolled in the requesting school or upon written notice from a court that the pupil has been placed in a juvenile correctional facility or a secured child-care institution.
- upon request by the student or parent or guardian of a minor student, behavioral records shall be provided.
- relating to a Department of Public Instruction audit or evaluation of a federal or state program to determine compliance with requirements under Wis. stats. 115 to 121.
- relating to immunization records disclosed to state and local health officials to determine compliance under Wis. Stat. 252.04.
- relating to lead-screening records disclosed to state and local health officials for any of the purposes of Wis. Stat. 254.11-178.
- in compliance with a court order under Wis. stats. 48.345(12)(b), 938.34(7d)(b), 938.396(1m)(c), or 939.78(2)(b)(2) after making a reasonable effort to notify the student's parent or legal guardian.
- if proper notice has been given, and the parent has not objected, directory data that relates to a pupil enrolled in the school district shall be disclosed, upon request, to any representative of a law enforcement agency (as defined in Wis. Stat. 165.83(1)(b)); district attorney or corporation counsel; county department (under Wis. stats. 46.215, 46.22, or 46.23); or a court of record or municipal court for the purpose of enforcing the student's school attendance, investigating alleged criminal or delinquent activity by the student, or responding to a health or safety emergency. (Note: Refer to a current version of the statutes for a complete listing of exceptions.)

Pupil Physical Health Records

Wis. Stat. 118.125(2m)(a)(b) describes an important link to Wis. stats. 146.81-84, relating to patient health-care records (see below). This statute establishes that any pupil physical health record that relates to a student's physical health and that is not a pupil physical health record, as described in Wis. Stat. 118.125(1)(cm), shall be treated as a patient health-care record under Wis. stats. 146.81-84. Further, this statute provides guidance related to the confidentiality requirements of any pupil record that concerns the results of a test for the presence of HIV under Wis. Stat. 252.15 (see Figure 30, "Categories of Pupil Records").

Patient Health-Care Records

Any pupil record that relates to a student's physical health and does not fall within the definition of pupil physical health records must be treated as a patient health-care record, in accordance with Wis. stats. 118.125(2m) and 146.81-84. In general, records relating to the health of a child that are authored by or under the supervision of a health-care provider (as defined in Wis. Stat. 146.81), except for records containing basic health information included in the definition of pupil physical health records, are treated as patient health-care records. It is important for school administrators and nurses–who are often the predominant school health-care providers–to know and understand access and confidentiality restrictions for patient health-care records. Wis. Stat. 146.81(1) defines a health-care provider as any of the following:

Figure 30

Categories of Pupil Records

Pupil Records

Directory Data

- name, address, telephone no.
- date and place of birth
- dates of attendance
- major field of study
- participation in activities and sports
- weight and height (athletic teams)
- photographs
- degrees and awards
- name of school most recently attended

Progress Records[2]

- grades
- courses taken
- attendance records
- extracurricular activities
- immunization records
- lead-screening records

Personal Notes

Notes and records for personal use and not shared with others are not available

Behavioral Records[3]

- psychological tests[1]
- personality evaluations[1]
- records of conversations with staff, parents, others[1]
- written statements about student's behavior[1]
- achievement or ability tests[1]
- IEP reports, plans, interventions and activities including related services[1]
- peace officer's records
- other records that are not progress records
- pupil physical health records:
  - —immunization records
  - —lead-screening records
  - —log of first aid
  - —log of medication administration
  - —hearing, vision, and scoliosis screening and follow-up records
  - —athletic permit card
  - —records concerning a child's ability to participate in an education program
  - —emergency medical card

Patient Health-Care Records

(subject to a different confidentiality standard 146.81-.84[4])

- medical or health reports from other health-care providers or parents
- records of conversations with physicians and other health-care providers
- summary or evaluation reports written by health-care providers in the school that discuss a student's health or medical history
- individualized health-care plans or other treatment plans regarding a student's health developed by health-care providers in the school setting (such as nurses, OTs, PTs, or physicians)
- other supporting documentation by health-care providers in the school setting (for example, in the case of nurses: nursing diagnoses, medical orders, professional judgements concerning a student's health)
- Medicaid documentation

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[1] Indicates behavioral records that may also be patient health care records.

[2] Progress records **must** be maintained for at least five (5) years after the student ceases to be enrolled.

[3] Behavioral records may be maintained for no longer than one (1) year after the student ceases to be enrolled, unless the parent or an adult student specifies in writing that the record may be retained longer.

[4] There are no legal provisions addressing the retention period of patient health-care records; however, a minimum retention period of 5-7 years is recommended (see text for discussion).

Note: Any record containing information about a child's health other than information identified in the pupil physical health record must be treated as a patient health-care record.

- a nurse licensed under Wis. Stat. 441
- a chiropractor licensed under Wis. Stat. 446
- a dentist licensed under Wis. Stat. 448
- an occupational therapist, occupational therapy assistant, physician assistant, or respiratory care practitioner certified under Wis. Stat. 448
- a dietitian certified under subch. IV of Wis. Stat. 448 (until June 30, 1999)
- an optometrist licensed under Wis. Stat. 449
- a pharmacist licensed under Wis. Stat. 450
- an acupuncturist certified under Wis. Stat. 451
- a psychologist licensed under Wis. Stat. 455
- a social worker, marriage and family therapist, or professional counselor certified under Wis. Stat. 457
- a speech and language pathologist or audiologist licensed under Subchapter II of Wis. Stat. 459 or a speech and language pathologist licensed by the Department of Public Instruction
- a partnership, corporation ,or limited-liability company of any of the above providers that provides health-care services
- an operational cooperative sickness care plan that provides services through salaried employees
- a hospice, inpatient health-care facility, or community-based residential facility

Certain school personnel may be certified by the Department of Public Instruction but may not meet the licensure or certification requirements of a health-care provider in this statute. For example, Wis. Stat. 146.81(1)(h) includes psychologists licensed under Wis. Stat. 455 as a health-care provider. Psychologists who are certified by the Department of Public Instruction but not licensed by Wis. Stat. 455 are not health-care providers and consent is required to gain access to a child's patient health-care record; this is also the case for school guidance counselors and school social workers.

Access to Patient Health-Care Records

Access to patient health-care records is provided for under Wis. stats. 146.82-83. Wis. Stat. 146.82(1) provides that patient health-care records must remain confidential. The DPI recommends that nurses, other school health providers, and school personnel should include in their pupil records information concerning a child's physical health (beyond basic health information found in pupil physical health records) only when such information is related to the child's educational needs; this is because the record must be treated as a patient health-care record. The DPI further recommends that patient health-care records be maintained separately from other pupil records, because the requirements related to the release of information from patient health-care records are more restrictive than the requirements for other pupil records.

Patient health-care records may be released without parental consent only to persons identified in Wis. Stat. 146.82(2). Situations in which patient health-care records can be released without informed consent include but are not limited to other health-care providers (as defined in Wis. Stat. 146.81(1)) when the performance of their duties requires access to such records. Examples include:

- the person is rendering assistance to the patient, the person is being consulted regarding the health of the patient, the life or health of the patient appears to be in danger and that the information may aid the person in rendering assistance, or the person prepares or stores those records (that is, a record custodian);
- records needed for billing, collection, or payment of claims;
- a lawful order of the court of record; and/or
- school district employees and agents who need the information to carry out specific duties relating to identification, evaluation, placement, and provision of a free, appropriate public education to a child with a disability under state and federal special education laws.

It must be emphasized that the school nurse should be involved with children who have health-care needs requiring attention during the school day. In accordance with the law and professional practice standards, the nurse has the specialized skill, judgment, and knowledge to explain, interpret, and determine what patient health-care information is educationally relevant and which school personnel need to have specific health information contained in the patient health record to support the child's learning. School district employees obtaining information from patient health-care records must keep the information confidential and may not disclose identifying information about any child whose patient health-care records are released.

Informed Consent

Patient health-care records may be released to others with informed consent of the child's parent. Informed consent means written consent that includes the:

- name of the patient whose record is being disclosed
- type of information to be disclosed
- types of health-care providers making the disclosure
- purpose of the disclosure, such as whether the disclosure is for further medical care, for an insurance application, to obtain payment of an insurance claim, for a disability determination, for a vocational rehabilitation evaluation, for legal investigation, or for another specified purpose
- individual, agency, or organization to which the disclosure may be made
- signature of the patient or a person authorized by the patient, the relationship of that person to the patient, or the authority of that person
- date on which the consent is signed
- time period during which the consent is effective

Wis. Stat. 146.83 provides that, upon submitting a statement of informed consent, any patient or other authorized person may access such records at any time during regular business hours after giving reasonable notice; receive a copy of the records upon payment of reasonable costs; and receive a copy of x-ray reports or have the x-rays referred to a health-care provider upon payment of reasonable costs. The health-care provider must note the time and date of each request by the parent or person authorized by the parent to inspect the records, the name of the inspecting person, and the time and date of inspection as well as identify the records released for inspection. It is important to note that a parent who has been denied periods of physical placement under Wis. Stat. 767.24(4) or 767.24(4)(b) does not have the rights of a parent with respect to access to the child's patient health-care records.

Each health-care provider must supply the parent with a statement paraphrasing the provisions of Wis. Stat. 146.83 when first providing health-care services to the child (see Appendix AAA for a prepared statement that can be used for this purpose).

Records Maintenance

Wis. Stat. 118.125(3) describes how and, generally, for what period of time pupil records must be maintained. A child's progress records must be maintained for at least five years after the child ceases to be enrolled.

A child's behavioral records, including pupil physical health records and special education records which are required to be maintained by a school district under Wis. Admin. Code PI11.37(2)(e), may be maintained for no longer than one year after the child ceases to be enrolled, unless the parent or adult student specifies in writing that the records be maintained for a longer period of time.

While there are no legal provisions explicitly addressing the period of time patient health-care records must be maintained or when they must be destroyed, Wis. stats. 19.21(4) and (5) establish a minimum retention period of seven years for records maintained by local governments. A local government may shorten the retention period if it obtains approval from the state Public Records and Forms Board under Wis. Stat. 16.61(3)(e). Additionally, the Wisconsin Medical Assistance Program advises schools who bill Medicaid to retain records related to claims for five years.

For more information on pupil records maintenance and retention, refer to the DPI's *Wisconsin Records Retention Schedule for School Districts* (1990). Useful information on record maintenance and retention for patient health-care records can be found in the Department of Health and Social Service's *Wisconsin Records Retention Handbook for Local Health Departments* (1994). Specific questions with regard to pupil records of children with disabilities are addressed in Appendix AAA, DPI Information Update 98.02, "Pupil Records of Children with Exceptional Educational Needs" (January 1998).

One concern that occasionally arises in the school setting is when patient health-care records are stored with pupil physical health records or with special education records. In either case, such health-care records may not be sufficiently protected by school district policy and, as a result, may be accessible to personnel who do not have a right to the information contained in the record (Wis. stats. 146.82-83) or do not have sufficient expertise to correctly interpret the information (Wis. Stat. 146.81). Once attached to pupil records, these patient health-care records are considered educational records and are accessible to a wide range of school personnel (Janda, 1978).

Other conflicts emerge with certain Wisconsin statutes that protect the rights of minors to confidentiality when they are seeking care for sexually transmitted diseases, family planning (Wis. stats. 48.981(2m) and 252.11(1m) and Wis. Admin. Code HHS 145.19), mental health, or drug abuse (Wis. Stat. 51.30). The conflict that emerges when documenting such services in the student's patient health-care record is that FERPA allows parents access to their child's pupil records.

Summary

Development and maintenance of record systems in schools is an important administrative and management function for both education and health-care professionals. It is critical for those professionals to provide leadership and advocacy to ensure protections and decrease barriers that benefit students, parents, the school, and other health and social service systems in the community. Researching and understanding federal and state laws and regulations is imperative when developing school records systems and associated district policies and procedures.

Funding

When developing a school health services program, it may quickly become apparent that the school district's resources are insufficient to respond to the health needs of every school-age child and youth. It is important for the school nurse to respond to needed health services in a careful manner, considering such issues as assessment, funding, and service delivery. Schools use a variety of funding resources to finance school health services. The traditional source of funding is general school aids authorized through an appropriation of the legislature and distributed by the DPI through a formula developed by the legislature. Still, schools must explore a variety of other sources in their attempt to fund health services for all students.

Local Voluntary/ Service Organizations

Local voluntary/service organizations can be approached to provide funding for specific school health-service budget items. For example, a local service club may assist with the purchase of an audiometer or other screening equipment needed for school health appraisals, or it may help purchase a glucometer for use by diabetic students in the school district. Examples of local service groups include Lions/Lioness Clubs, Kiwanis Clubs, Masons, Rotary Clubs, and Optimist Clubs as well as local parent-teacher organizations. Each service organization has local service programs that they generously support with human and financial resources.

Grants

Public and private grants may be a good source of funding to start new programs. School districts may receive funding for various school health programs by applying for funds granted by federal, state, or local governments; private foundations; or nonprofit organizations. Applying for grants may take considerable staff time, but, if successful, it is an innovative way to fund programs and services not supported by other sources.

School-Based Medicaid Services

Although schools are responsible for providing necessary school health services to children with disabilities, funding from sources outside the district may be available and should be carefully considered. Schools may access a parent's insurance and Medicaid to pay for necessary special education services in circumstances where the parent's would incur no realistic threat of a financial loss.

Wisconsin Act 27 (1995) established the School Based Services (SBS) benefit, which provides Medicaid coverage for certain services rendered in accordance with Part B of the Individuals with Disabilities Education Act (IDEA). As required under education laws, SBS providers must obtain permission to provide Individualized Education Program (IEP) or Individualized Family Service Program (IFSP) services.

This benefit allows school districts and cooperative educational service agencies (CESAs) to become certified as SBS providers and bill the Wisconsin Medicaid program for medically necessary services provided to Medicaid-eligible children under age 21, including any school term in which the individual becomes 21 years old.

In accordance with Wis. Admin. Code HSS 101 (96m), all Medicaid-covered services must be medically necessary. An SBS service is medically necessary when the service meets *all* of the following conditions:

- identifies, treats, manages, or addresses a medical problem or a mental, emotional, or physical disability;
- is identified in the school district's or CESA's IEP/IFSP for the child;
- is necessary for a child to benefit from special education; and
- is referred or prescribed by a physician, when appropriate.

Certain services may also be referred or prescribed by a nurse practitioner with prescribing authority or a licensed Ph.D. psychologist. All referrals or prescriptions must be updated annually.

Services covered under the SBS benefit include:

- speech-language
- audiology and hearing
- physical therapy
- occupational therapy
- nursing
- psychological services
- counseling
- social work
- developmental testing and assessments when they result in an IEP/IFSP
- transportation
- durable medical equipment

For Medicaid coverage of these SBS services, there must be a care plan which identifies treatment goals that are measurable and outcome oriented.

Covered nursing services include but are not limited to

- evaluation and management services, including screens and referrals for health needs;
- treatment and other measures; and
- medication management.

All Medicaid-covered nursing services must be

- relevant to the child's medical needs;
- prescribed or referred by a physician or advanced practice nurse with prescribing authority, identified in an IEP or IFSP; and
- provided by a registered nurse or by a delegated, competent nonprofessional school staff person in selected situations (in accordance with the standards established in Wis. Admin. Code N6.03).

For additional information about and assistance with SBS coverage of nursing and other health services, school districts and parents may contact Wisconsin Department of Health and Family Services, Bureau of Health-Care Financing, School Based Services staff.

IDEA Flow-Through

Because Wisconsin school districts are not reimbursed under categorical funding for services provided by nurses to children receiving special education, districts should carefully explore and consider using such potential funding sources as IDEA flow-through and/or discretionary funds. For more information or to apply, contact the Wisconsin Department of Public Instruction, Division for Learning Support: Equity and Advocacy, Exceptional Education Mission Team.

Program for Children with Special Health Care Needs

The Program for Children with Special Health Care Needs (CSHCN), managed by the Wisconsin Division of Health, is federally funded with Title V Maternal and Child Health Block Grant. The program provides consultation and/or financial assistance for families of children age 20 or younger who have chronic illnesses or disabilities and have special health-care needs.

To receive help through CSHCN, families may call directly or be referred by schools, physicians, or other community-based health and social service providers. Prior approval and financial and medical eligibility determine assistance for services such as:

- specialized medical care
- audiology services
- outpatient hospital care
- medications
- medically necessary equipment

Additional information about and a summary of eligibility requirements for the CSHCN Program may be obtained by contacting the CSHCN staff at the Wisconsin Department of Health and Family Services, Division of Health, (608) 266-3886 or (800) 441-4576.

Katie Beckett Program

The Katie Beckett Program offers medical assistance and counseling to disabled children age 18 and under who live at home. Eligibility is determined based on information provided in a completed application. Only the income and assets of the child are considered when determining eligibility, not the income and assets of the parents.

It is important to note that it is possible for children to participate in both Supplemental Security Income and the Katie Beckett Program.

For additional information (including eligibility requirements) about the Katie Beckett Program, contact the Wisconsin Department of Public Instruction, Division of Community Services, (608) 266-9590.

Supplemental Security Income

Supplemental Security Income (SSI) is a federal cash-assistance program that provides monthly payments to low-income aged, blind, and disabled persons. The program is based on nationally uniform eligibility standards and payment levels.

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996

- requires a child to have a physical or mental condition that can be medically proven and which results in marked and severe functional limitations.
- requires that the medically proven physical or mental health condition last a year or longer or be expected to result in death.
- states that a child may not be considered disabled if s/he is working at a job considered to be substantial work.

To learn more about Supplemental Security Income and benefits available to disabled children, contact a local Social Security Office or call the Social Security Administration at (800) 772-1213 (voice) or (800) 325-0778 (TTY).

Liability

School nurses are responsible for acquiring adequate personal professional liability insurance against claims of negligence or malpractice. Most school districts provide liability insurance for their employees under a general liability policy. It is prudent for school nurses hired by the district, working as independent contractors, or employed by a CESA or other agency to carry their own professional liability insurance.

Litigation can arise from a wide variety of perceived impingement's on a child's rights, including but not limited to: a parent's complaint about the quality of care provided by nonprofessional school health personnel delegated to carry out a nursing act, failure to report suspected child abuse, confidentiality and privacy, the right to refuse service, or lack of informed consent.

A nurse who, working as an employee of a school or other agency or institution, receives a summons alleging professional misconduct should notify the district administrator immediately and request representation by the school's liability insurance carrier. The nurse who also has personal professional liability coverage should also immediately notify that insurance carrier, advising its representative of any contacts made with the school. A nurse acting as an independent contractor should immediately notify his/her professional liability insurance carrier. A nurse who, acting as an independent contractor, has no personal professional liability coverage may wish to immediately hire a competent employment defense attorney.

A hearing or court proceeding may require a nurse to submit documentation of services provided to a child. As school nurses write reports and keep records, they should keep in mind that courts or hearing officers can use these records to support or refute a litigant's allegations. To protect themselves and the students and staff members they serve, nurses should adhere to the following documentation guidelines (Fuetz-Harter, 1991):

- Keep records in accordance with established guidelines; document nursing activities and relevant student responses in an accurate, objective, concise, thorough, timely, and well-organized manner.
- Sign and date all entries.
- Document symptoms in the student's or staff member's own words.
- Know what level or type of records are appropriate for nonprofessional school health personnel to sign.
- Write legibly, using only approved abbreviations.
- Make all entries in permanent ink (black ink is preferred).
- When an error is made, draw a thin line through the error (allowing the original content to remain legible) and date and initial the change; in some instances, it may be prudent to ask someone to witness the correction.
- Avoid gaps in both content and format; write on every line of the record.
- Be specific and objective, including only essential information and precise measurements.
- Physician orders should be in writing; they should be clear, sufficiently detailed, dated, time limited, and signed.
- When it is necessary to accept a telephone order, ask the health-care provider to verify the order by sending a written, signed confirmation; in such cases, a second person on the line can serve as a witness.
- Double check your work.

School Nurse Performance Evaluation

School administrators can readily assess the administrative performance of nurses in the school setting by observing them performing essential job activities, by surveying those who work with school nurses, and reviewing records and reports. The essential activities in the job performance of school nurses are identified in the position description (see Appendix A) and may include

- establishing and maintaining a comprehensive school health-services program;
- applying appropriate nursing theory in decision making;
- developing individualized health plans for students;
- providing direct nursing services, both individual and group;
- providing indirect nursing services through collaboration with other school staff and community partners;
- assisting students, their families, and interested groups to achieve optimal levels of health through health education;
- communicating and collaborating with children, their families, student-service providers, teachers, nonprofessional school health personnel, administrators, medical advisors, and other community partners; and
- participating in peer review and other means of evaluation to ensure quality clinical nursing care.

In addition to these activities (described in detail throughout other chapters of this guide), nurses educate other nurses, educators, school personnel, and community partners; supervise nonprofessional school health personnel; and monitor and maintain their own professional development and adherence to professional standards and ethics.

When evaluating performance, the director of student services, building principal, or other designated administrator follows performance-appraisal criteria based on the school nurse's position description. Ideally, performance criteria should be developed jointly by the evaluating administrator and the school nurse.

Many educational administrators find it difficult to evaluate the quality of nursing care or clinical skills of the nurse, because they are not professionally prepared in health administration or nursing. However, the quality of nursing activities are reflected in the

- documented achievement of outcomes related to school health service program goals, individual student IHPs, and numerous other activities.
- ability of the nurse to interpret the health needs of children in the school setting and project functional outcomes that prevent, modify, or remove health-related barriers in the school environment.
- ability of the nurse to foster a mutual commitment to and responsibility for student health and learning readiness among school and community partners.

Administrators can assist nurses in developing health- and education-related outcome measures that demonstrate improved health status and learning readiness of children. Nurses can assist administrators in (1) understanding the interactive nature of health and education when evaluating school environments that support children's health, development, and learning readiness; (2) realizing the importance of developing school health information, management, and service systems that provide necessary data to monitor trends and inform policy development; and (3) linking with local health departments and/or other nursing colleagues familiar with school nursing practice to explore clinical consultation, mentoring, or peer-evaluation methods.

Several resources that offer sample tools for evaluating school nurse job performance are available through the National Association of School Nurses (NASN) and the American School Health Association (ASHA):

- *Evaluating School Nursing Practice: A Guide for Administrators* (ASHA, 1985)
- *Job Performance Evaluation: Guidelines for School Nurses* (NASN, 1995)
- *An Evaluation Guide for School Nursing Practice Designed for Self and Peer Review* (NASN, 1985)

Nurses hired by the school district undergo evaluation in accordance with district personnel policies and/or any master agreement, if applicable. Nurses contracted by the school district undergo an annual evaluation relative to the agreed-on service expectations outlined in a memorandum of understanding, purchase-of-service agreement, or contract. Such agreements or contracts should specify the expectation of ongoing evaluation or assessment of performance and the resolution of deficiencies.

Collaboration

Given the primarily rural nature of Wisconsin schools, the nurse in the school is frequently isolated from other student-service providers and health-care colleagues as well as from professional resources for consultation on health issues. Thus, the need to update one's knowledge and skills through continuing education and dialogue with professional colleagues is of utmost importance. Following are some recommended strategies for collaboration:

Student-Service Providers

School nurses most often work in collaboration with school counselors, school social workers, school psychologists, and directors of student services in meeting the health and education needs of individual and groups of students. Creating opportunities within and outside the school district to discuss areas of role overlap and ways of providing effective student services can ensure individual as well as collective support for student-services roles.

Further information about student-service providers and student-service teams is available in *Pupil Services: A Resource and Planning Guide* (Wisconsin Department of Public Instruction, 1995).

Local Health Departments

Local health departments have many responsibilities, most of which are intended to foster a healthy population; these responsibilities coincide with school health-services programs. Four basic public health services that naturally coincide with school health programs include: (1) surveillance, investigation, control, and prevention of communicable diseases; (2) disease prevention; (3) health promotion; and (4) human hazard prevention and control. Partnerships with local health departments can be a source of enduring mutual support and are essential for the efficient and effective use of school health resources. Other opportunities for collaboration may include

- assessing and clarifying health needs of the community;
- developing joint strategies to respond to the health and educational needs of students, their families, and staff members through program planning, development, and evaluation;
- providing orientation and/or mentoring for school nurses regarding emerging public health issues and their connection to schools and educational programming; and
- networking through consultation, meetings, mailings, e-mail, and continuing education opportunities.

Community Agencies

Partnerships with local community-based agencies can be another source of ongoing support and are essential for the efficient use of school health resources. Opportunities for collaboration that will benefit both the schools and the community might be:

- assessing and clarifying health needs of the community, including the school-age population, to develop joint strategies to respond to health-related educational needs of students, staff, and families;
- providing orientation and/or mentoring regarding emerging public health issues and their connection to schools and education programming; and
- networking through consultation, meetings, mailings, and continuing education opportunities.

Local Schools of Nursing

School nurses may wish to develop relationships with nursing educators of local universities. Examples of collaboration include agreements with the university to provide consultation; placement of nursing students in the school setting as a part of their nursing practicum; and guest lectures in nursing, medical, education, or other university programs.

School nurses have unique opportunities to design and collaborate with university colleagues in research studies addressing the complex and diverse health needs of children and adolescents. Collaboration may also occur with education colleagues who focus on providing student services or health-promotion and disease-prevention teaching strategies.

Other School Nurses

Developing opportunities to consult with colleagues in the school nursing specialty area is essential to maintaining skills and ensuring support in a challenging role. In addition, the sharing of successful programs, policies, and procedures can result in improved school health programs across Wisconsin. Collaboration with other school nurses may take the form of involvement in the Wisconsin Association of School Nurses, regular regional meetings, peer review, telephone or e-mail consultation, or continuing education.

Conclusion

Each of the administrative issues described in this chapter contribute to an effective school health-services program. Key components include community and school needs assessments, program planning and evaluation, policy development, school record systems, funding, professional liability considerations, performance evaluation, and collaboration. Because of the important role health plays in learning readiness–building the capacity of children to become successful, lifelong learners and productive, contributing citizens–school health services are critically important if we are to nurture children's growth, learning, health, and well-being.

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National, Regional, and State Resources 12

National Resources

General

Administration on Aging
330 Independence Avenue, SW
Washington, DC 20201
(202) 401-4541

Advocates for Youth
1025 Vermont Avenue, NW, Suite 200
Washington, DC 20005
(202) 347-5700
E-mail: advocates @internetnci/com.

American Academy of Family Physicians
8880 Ward Parkway
Kansas City, MO 64114-2797
(800) 274-2237
(816) 333-9700
Fax: (816) 822-9715
www.aafp.org

American Academy of Pediatrics
141 Northwest Point Boulevard
P.O. Box 927
Elk Grove Village, IL 60009-0927
(800) 433-9016
(847) 228-5005
www.aap.org

American Association for World Health
1825 K Street, Suite 1208
Washington, DC 20006
(202) 466-5883

American Association of School Administrators
1801 North Moore Street
Arlington, VA 22209
(703) 528-0700
Fax: (703) 841-1543
www.aasa.org

American Bar Association
740 15th Street, NW
Washington, DC 20005
(202) 662-1000
Fax: (202) 662-1032
E-mail: jryan3@staff.abanet.org

American Cancer Society
1599 Clifton Road, N.E.
Atlanta, GA 30329
(404) 320-3333

American Chiropractic Association
1701 Clarendon Boulevard
Arlington, VA 22209
(800) 986-4636

American Counseling Association
5999 Stevenson Avenue
Alexandria, VA 22304
(703) 823-9800

American Federation of Teachers
555 New Jersey Avenue, NW
Washington, DC 20001-2079
(202) 879-4400
Fax: (202) 879-4545
www.aft.org

American Health Care Association
1201 L Street, NW
Washington, DC 20005
(202) 842-4444

American Health Foundation
320 East 43rd Street
New York, NY 10017
(212) 953-1900

American Heart Association
7272 Greenville Avenue
Dallas, TX 52231
(214) 373-6300
www.amhrt.org

American Lung Association
1740 Broadway
New York, NY 10019
(212) 315-8700
www.lungusa.org

American Medical Association
515 North State Street
Chicago, IL 60610
(312) 464-5000
www.ama-assn.org/adolhlth/adolhlth.htm

American Nurses Association
600 Maryland Avenue, SW, Suite 100 West
Washington, DC 20024
(202) 651-7000
www.ana.org

American Nurses Credentialing Center
600 Maryland Avenue, SW, Suite 100 West
Washington, DC 20024-2571
(800) 284-2378
(202) 651-7000
Fax: (202) 651-7004

American Occupational Therapy Association
4720 Montgomery Lane
P.O. Box 31220
Bethesda, MD 20824-1220
(301) 652-2682

American Optometric Association
243 North Lindbergh Boulevard
St. Louis, MO 63141
(314) 991-4100

American Physical Therapy Association
1111 North Fairfax Street
Alexandria, VA 22314
(703) 684-2782

American Psychological Association
750 First Street, NE
Washington, DC 20002-4242
(202) 336-5970
www.apa.org\ed\cpse.html

American Psychiatric Association
1400 K Street, NW
Washington, DC 20005
(202) 682-6220

American Public Health Association
1015 15th Street, NW, Suite 300
Washington, DC 20005
(202) 789-5600
Fax: (202) 789-5661
www.apha.org

American School Counselor Association
801 North Fairfax Street, Suite 310
Alexandria, VA 22314
(703) 683-2722
Fax: (703) 683-1619
www.schoolcounselor.org/

American School Health Association
7265 State Route 43
P.O. Box 708
Kent, OH 44240
(330) 678-1601
Fax: (330) 678-4526
http://sunsite.unc.edu/ASHA/

American Speech-Language-Hearing Association
10801 Rockville Pike
Rockville, MD 20852
(800) 638-8255
(301) 897-8682
www.asha.org

Association for the Care of Children's Health
19 Mantua Road
Mt. Royal, NJ 08601
(609) 224-1742
Fax: (609) 423-3420

Association of State and Territorial Health Officials
1275 K Street, NW, Suite 800
Washington, DC 20005
(202) 371-9090
Fax: (202) 371-9797
www.astho.org

Better Sleep Council
333 Commerce Street
Alexandria, VA 22314
(703) 683-8371
Fax: (703) 683-4503

Channing L. Bete
200 State Road
South Deerfield, MA 01373
(413) 665-7611

Child Health Foundation
10630 Little Patuxent Parkway, Suite 126
Columbia, MD 21044
(301) 596-4514
Fax: (410) 992-5641

Council of Chief State School Officers
One Massachusetts Avenue, NW, Suite 700
Washington, DC 20001-1431
(202) 408-5505
http:/www.ccsso.org

Health Care Financing Administration
200 Independence Avenue, SW
Washington, DC 20201
(202) 690-6113
http://www.hcfa.gov

Health Resources and Services Administration
5600 Fishers Lane, Room 14-45
Rockville, MD 20857
(301) 443-2086
www.hrsa.dhhs.gov

Helen Keller National Center
111 Middle Neck Road
Sands Point, NY 11050
(516) 944-8900
(516) 944-8637 (TTY)

Indian Health Service
5600 Fishers Lane, Room 6-05
Rockville, MD 20857
(301) 443-3593
www.tucson.ihs.gov

MEDLINE
National Library of Medicine
8600 Rockville Pike
Bethesda, MD 20894
(888) 346-3656
(301) 594-5983
http://www.nlm.nih.gov/databases/freemedl.html

National Assembly on School-Based Health Care
1522 K Street, NW, Suite 600
Washington, DC 20005
(202) 289-5400

National Association for the Education of Young Children
1509 16th Street, NW
Washington, DC 20036-1426
(800) 424-2460
(202) 232-8777
Fax: (202) 328-1846
www.naeyc.org

National Association of County Health Officers
440 First Street, NW, Suite 500
Washington, DC 20001
(202) 783-5550

National Association of Elementary School Principals
1615 Duke Street
Alexandria, VA 22314-3483
(703) 684-3345
Fax: (703) 548-6021
www.naesp.org

National Association of Partners in Education
901 North Pitt Street, Suite 320
Alexandria, VA 22314
(703) 836-4880
Fax: (703) 836-6941

National Association of Pediatric Nurse Associates and Practitioners
1101 Kings Highway, North, Suite 206
Cherry Hill, NJ 08034
(609) 667-1773
Fax: (609) 667-7187
www.napnap.org/

National Association of School Nurses
P.O. Box 1300
Scarborough, ME 04070-1300
(207) 883-2117
Fax: (207) 883-2683
E-mail: NASN@aol.com
http://www.nasn.org

National Association of Secondary School Principals
1904 Association Drive
Reston, VA 20191
(703) 476-5432
www.nassp.org

National Association of State Boards of Education
1012 Cameron Street
Alexandria, VA 22314
(703) 684-4000
Fax: (703) 836-2313
www.nasbe.org

National Association of State School Nurse Consultants
c/o American School Health Association
7263 State Route 43
Kent, OH 44240
(602) 220-6550
lserver.aea14.k12.ia.us/swp/tadkins/nassnc/nassnc.html

National Board for Certification of School Nurses
1211 Avenue of the Americas, 15th Floor
New York, NY 10036
(212) 852-0400
Fax: (212) 852-0414

National Congress of Parents and Teachers
330 North Wabash Avenue, Suite 2100
Chicago, IL 60611-3690
(312) 670-6782
Fax: (312) 670-6783
www.pta.org

National Education Association
1201 16th Street, NW
Washington, DC 20036
(202) 822-7570
Fax: (202) 822-7775
www.nea.org

National Institute of Mental Health
5600 Fishers Lane, Room 7C-02
Bethesda, MD 20857-8030
(301) 443-4513
Fax: (301) 443-4279
E-mail: nimhinfo@nih.gov
www.nimh.nih.gov

National Institutes of Health
9000 Rockville Pike
Bethesda, MD 20892
(301) 496-2351
www.nih.gov

National Library of Medicine
8600 Rockville Pike
Bethesda, MD 20894
(888) 346-3656
www.nlm.nih.gov

National Maternal and Child Health Clearinghouse
2070 Chain Bridge Road, Suite 450
Vienna, VA 22182-2536
(703) 356-1964
Fax: (703) 821-2098
E-mail: nmchc@circsol.com
www.circsol.com/mch

National Mental Health Association
1021 Prince Street
Alexandria, VA 22314-2971
(800) 969-6642
(703) 684-7722
Fax: (703) 684-5968
E-mail: nmhainfo@aol.com
www.worldcorp.com/dc-online/nmha/index.html

National Mental Health Services
P.O. Box 42490
Washington, DC 20015
(800) 789-2647
(301) 443-9006 (TTY)
Fax: (301) 984-8796
E-mail: ken@mentalhealth.org
www.mentalhealth.org/

National School Boards Association
1680 Duke Street
Alexandria, VA 22314
(703) 838-6722

National Scoliosis Foundation
72 Mount Auburn Street
Watertown, MA 02172

National Society to Prevent Blindness
500 East Remington Road, Suite 200
Schaumburg, IL 60173
(800) 331-2020
(847) 843-2020

Occupational Safety and
Health Administration
200 Constitution Avenue, NW
Washington, DC 20210
(202) 219-8148
www.osha.gov/

Office of Minority Health Resource Center
P.O. Box 37337
Washington, DC 20013-7337
(800) 444-6472
(301) 589-0951 (TTY)
Fax: (301) 589-0884
E-mail: info@omhrc.gov
www.omhrc.gov

Robert Wood Johnson Foundation
School-Based Adolescent Health Care Program
1350 Connecticut Avenue, NW, Suite 505
Washington, DC 20036
(202) 466-3396

Search Institute
Thresher Square West, Suite 210
700 South Third Street
Minneapolis, MN 55415
(612) 376-8955
Fax: (612) 376-8956

Social Security Administration
6401 Security Boulevard, Room 4-C-5 Annex
Baltimore, MD 21235
(800) 772-1213
(800) 325-0778 (TTY)
http://www.ssa.gov

U.S. Coast Guard
2100 Second Street, SW
Washington, DC 20593-0001
(800) 368-5647
(202) 267-1060

U.S. Department of Education
Office of Civil Rights
400 Maryland Avenue, SW, Room 5000
Switzer Building
Washington, DC 20202
(202) 205-5413

Univ. of Colorado Office of School Health
4200 East 9th Avenue
Box C-287
Denver, CO 80262
(303) 270-7435
Fax: (303) 270-3198
http://www.ucl.sc.edu/sn/shrs

Adolescent Sexuality, Pregnancy, and Parenting

American Anorexia/Bulimia Association
c/o Regent Hospital
425 East 61st Street
New York, NY 10021
(212) 891-8686

Center for Child and Adolescent Obesity
Department of Family and Community Medicine
University of California-San Francisco
400 Parnassus Street
P.O. Box 0900
San Francisco, CA 94143-0900
(415) 476-2502
Fax: (476) 457-3331

Healthy Mothers-Healthy Babies
409 12th Street, SW
Washington, DC 20024
(202) 863-2458

La Leche League International
P.O. Box 4079
Schaumburg, IL 60168-4079
(847) 519-9585
Fax: (847) 519-0035
www.drairienet.org/llli

National Adolescent Health
Information Center
Department of Adolescent Medicine
University of California-San Francisco
400 Parnassus Avenue, Room AC-01
San Francisco, CA 94143-0374
(415) 476-2184
Fax: (415) 476-6106

National Clearinghouse on
Runaway and Homeless Youth
P.O. Box 13505
Silver Spring, MD 20911-3505
(301) 608-8098
Fax: (301) 608-8721

National Lesbian and
Gay Health Association
1407 S Street, NW
Washington, DC 20009
(202) 939-7880
Fax: (202) 234-1467
www.serve.com/nlgha/hewal.htm

Planned Parenthood Federation of America
810 Seventh Avenue
New York, NY 10019
(212) 541-7800
Fax: (212) 245-1845
www.ppfa.org/ppfa/index.html

Sexuality Information and Education Council of the U.S.
130 West 42nd Street, Suite 350
New York, NY 10036-7901
(212) 819-9770
Fax: (212) 819-9776
E-mail: siecusrpt@aol.com
www.seicus.org/

SIDS Alliance
1314 Bedford Avenue, Suite 210
Baltimore, MD 21208
(800) 221-7437

The Society for Adolescent Medicine
1916 NW Copper Oaks Circle
Blue Springs, MO 64015
(816) 224-8010

U.S. Department of Health and Human Services
Office of Population Affairs Clearinghouse
P.O. Box 30686
Bethesda, MD 20824-0686
(301) 654-6190
www.hhs.gov/progorg/opa/pregtrnd.html

Alcohol and Other Drugs

Interassociation Task Force on Campus Alcohol and Other Substance Abuse Issues
P.O. Box 100430
Denver, CO 80250
(303) 871-3068

National Association of Alcoholism and Drug Abuse Counselors
1911 North Fort Myer Drive, Suite 900
Arlington, VA 22209
(703) 741-7686

National Clearinghouse for Alcohol and Drug Information
P.O. Box 2345
Rockville, MD 20847-2345
(800) 729-6686 (Voice)
(800) 487-4889 (Dial Access TTY)
E-mail: http://www.health.org/

National Council on Alcoholism and Drug Dependence
12 West 21st Street
New York, NY 10010
(212) 206-6770

Substance Abuse and Mental Health Services Administration
5600 Fishers Lane
Rockville, MD 20857
(301) 443-8956
www.samhsa.gov

Child Abuse and Neglect

Children's Defense Fund
25 E Street, NW
Washington, DC 20001
(202) 628-8787
Fax: (202) 662-3510

National Children's Advocacy Center
200 Westside Center Square, Suite 700
Huntsville, AL 35801
(800) 239-9939
(205) 534-6868
Fax: (205) 534-6883

National Clearinghouse on Child Abuse and Neglect Information
P.O. Box 1182
Washington, DC 20013
(800) 394-3366
(703) 385-7565
Fax: (703) 385-3206
E-mail: nccanch@calib.com
www.calib.com/nccanch

National Committee to Prevent Child Abuse
332 South Michigan Avenue, Suite 1600
Chicago, IL 60604
(312) 663-3520

National Network of Youth Services
1319 F Street, NW, Suite 401
Washington, DC 20004-1113
(202) 783-7949
Fax: (202) 783-7955
www.nn4youth.org

Children with Special Health Needs

Alexander Graham Bell
Association for the Deaf
3417 Volta Place, NW
Washington, DC 20007-2778
(202) 337-5220 (Voice/TDD)

American Speech-Language-Hearing
Association
10801 Rockville Pike
Rockville, MD 20852
(800) 638-6868 (Voice/TDD)

Autism Society of America
7910 Woodmont Avenue, Suite 650
Bethesda, MD 20814-3015
(301) 657-0881

Brain Injury Association
105 North Alfred Street
Alexandria, VA 22314
(703) 236-6000
Fax: (703) 236-6001

Center for Mental Health in Schools
Department of Psychology
University of California-Los Angeles
405 Hilgard Avenue
Los Angeles, CA 90095-1563
(310) 825-3634
Fax: (310) 206-8716

Children with Special Health Care Needs
Department of Health and Family Services
Division of Health
1414 East Washington Avenue
Madison, WI 53703
(800) 441-4576
(608) 266-3886

Collaboration Among Parents
and Health Professionals
National Parent Resource Center
Federation for Children with Special Needs
95 Berkeley Street, Suite 104
Boston, MA 02116
(800) 331-0688
(617) 482-2915
Fax: (617) 695-2939

Council for Exceptional Children
1920 Association Drive
Reston, VA 20191-1589
(703) 620-3660 (Voice/Deaf Access)
Fax: (703) 264-9494

Institute for Health and Disability
University of Minnesota
420 Delaware Street, S.E., Box 721
Minneapolis, MN 55455-0392
(800) 333-6293
(612) 626-2825/624-3939 (TDD)
Fax: (612) 626-2134
http://www.peds.umn.edu/Centers

Kids on the Block
9385-C Gerwig Lane
Columbia, MD 21046
(800) 368-5437
(410) 290-9095
Fax: (410) 290-9358

Learning Disabilities Association of America
4156 Library Road
Pittsburgh, PA 15234-1349
(412) 341-1515 (Voice)
Fax: (412) 344-0224
www.ldanatl.org

Minnesota Foundation for
Better Hearing and Speech
444 Cedar Street, Suite 1150
St. Paul, MN 55101
(612) 223-5130 (Voice/TDD)

National Association for
Hearing and Speech Action
814 Thayer Avenue
Silver Spring, MD 20901
(800) 638-8255 (Voice/TDD)

National Association for Home Care
228 7th Street, SE
Washington, DC 20003
(202) 547-7424
www.nahc.org

National Center for
Youth with Disabilities
University of Minnesota
420 Delaware Street, S.E., Box 721
Minneapolis, MN 55455-0392
(800) 333-6293
(612) 626-2825
(612) 624-3939 (TDD)
Fax: (612) 626-2134

National Hospice Association
1901 North Moore Street, Suite 901
Arlington, VA 22209
(800) 658-8898
(703) 243-5900
Fax: (703) 525-5762

National Information Center for Children and Youth with Disabilities
P. O. Box 1492
Washington, DC 20013
(800) 695-0285

National Information Center on Deafness
Gallaudet University
800 Florida Avenue, NE
Washington, DC 20002-3695
(202) 651-5051 (Voice)
(202) 651-5052 (TDD)

National Organization of Rare Diseases
P.O. Box 8923
New Fairfield, CT 06812-1783
(800) 999-6673
(203) 746-6518
Fax: (203) 746-6481
www.pcnet.org/~orphan/

National Parent Network on Disabilities
1200 G Street, NW, Suite 800
Washington, DC 20005
(202) 434-8686 (Voice/TDD)
Fax: (202) 434-8707

National Spinal Cord Injury Association
600 West Cummings Park, Suite 2000
(781) 935-2722
Fax: (781) 932-8369

Parents Helping Parents: The Family Resource Center for Children with Special Needs
3041 Alcott Street
Santa Clara, CA 95054
(408) 727-5775
Fax: (408) 727-0182

President's Committee on Employment of People with Disabilities
1331 F Street, NW, 3rd Floor
Washington, DC 20004
(202) 376-6200

Project School Care
Children's Hospital
300 Longwood Avenue
Boston, MA 02115
(617) 355-6741
Fax: (617) 734-7940

Society for Cognitive Rehabilitation
P.O. Box 53067
Albuquerque, NM 87153-3067

Support Center for School-Based and School-Linked Health Care
1025 Vermont Avenue, NW, Suite 200
Washington, DC 20005
(202) 347-5700
Fax: (202) 347-2263

The Food Allergy Network
10400 Eaton Place
Fairfax, VA 22030
(800) 929-4040
(703) 691-3179

Communicable Diseases

Association for Practitioners in Infection Control
1016 16th Street, NW, 6th Floor
Washington, DC 20036
(202) 296-2742

Centers for Disease Control and Prevention
Building 1, Room B-631
1600 Clifton Road, N.E.
Atlanta, GA 30333
(404) 639-3286
www.cdc.gov

Morbidity and Mortality Weekly Report
www.cdc.gov/epo/mmwr/mmwr.htm

National Center for Chronic Disease Prevention and Health Promotion
www.cdc.gov/nccdphp/nccdhome.htm

National Center for Environmental Health
www.cdc.gov/nceh/ncehhom.htm

National Center for Health Statistics
www.cdc.gov/nchswww/nchshome.htm

National Center for HIV, SIDS, and TB Prevention
www.cdc.gov/nchstp/od/nchstp.html

National Center for Injury Prevention and Control
www.cdc.gov/ncipc/ncipchm.htm

Scientific Data, Surveillance, and Health Statistics and Laboratory Information
www.cdc.gov/scientific.htm

National Coalition for Adult Immunization/ National Foundation for Infectious Diseases
4733 Bethesda Avenue, Suite 750
Bethesda, MD 20814-5228
(301) 656-0003

National Council of LaRaza
1111 19th Street, NW, Suite 1000
Washington, DC 20036
(202) 785-1670
www.hispanic.org/nclrndv.htm

National Pediculosis Association
P.O. Box 610189
Newton, MA 02161
(781) 449-6487
Fax: (781) 449-8129
www.headlice.org

Vacunas Desde La Cuna (National Hispanic Immunization Hot Line)
P.O. Box 13827
Research Triangle Park, NC 27709
(800) 232-0233 (Spanish)
(800) 232-2522 (English)
(Hotline hours: 8:00 a.m.–11:00 p.m. EST)
http://sunsite.unc.edu/ASHA/

Emergency Medical Services

American Heart Association
320 East 43rd Street
New York, NY 10017
(212) 953-1900
www.amhrt.org

American Red Cross
430 17th Street, NW
Washington, DC 20006
(202) 737-8300

American Trauma Society
8903 Presidential Parkway, Suite 512
Upper Marlboro, MD 20772-2656
(800) 556-7890
Fax: (301) 420-0617

Emergency Medical Services for Children
National Resource Center
111 Michigan Avenue, NW
Washington, DC 20010
(202) 884-4927
http://www.ems-c.org

Health Education

Academy for Educational Development
1875 Connecticut Avenue, NW, 9th Floor
Washington, DC 20009
(202) 884-8700
Fax: (202) 884-8400

American Association for Health Education
1900 Association Drive
Reston, VA 20191
(703) 476-3437
Fax: (703) 476-6638

American Red Cross
Office of HIV/AIDS Education
8111 Gatehouse Road, Sixth Floor
Falls Church, VA 22042
(703) 206-7414

Association for Supervision and Curriculum Development
1250 North Pitt Street
Alexandria, VA 22314
(703) 549-9110
www.ascd.org

Future Homemakers of America
1910 Association Drive
Reston, VA 20191
(703) 476-4900
Fax: (703) 860-2713

National Education Association Health Information Network
1201 16th Street, NW, Suite 521
Washington, DC 20036-3290
(202) 822-7570
Fax: (202) 822-7775

National Health Education Consortium
Institute for Educational Leadership
1001 Connecticut Avenue, NW, Suite 310
Washington, DC 20036
(202) 822-8405
Fax: (202) 872-4050
www.nhec.org

Centers for Disease Control and Prevention
1600 Clifton Road, N.E.
Atlanta, GA 30333
(404) 639-3286

National AIDS Clearinghouse
(800) 458-5231

National Center for Education in Maternal and Child Health
2070 Chain Bridge Road, Suite 450
Vienna, VA 22182
(703) 821-8955/356-1964
www.os.dhhs.gov/hvsa/mchb

National Center for Health Education
72 Spring Street, Suite 208
New York, NY 10012
(212) 334-9470
Fax: (212) 334-9845

National Center for School-Based Health Information Systems
Children's Hospital
1056 East 19th Avenue
Denver, CO 80218
(303) 861-6133
Fax: (303) 837-2962

National Cholesterol Education Program Information Center
P.O. Box 30105
Bethesda, MD 20824-0105
(301) 251-1222
Fax: (301) 251-1223

National High Blood Pressure Education Program Information Center
P.O. Box 30105
Bethesda, MD 20824-0105
(301) 251-1222
Fax: (301) 251-1223

Office of School Health
University of Colorado School of Nursing
4200 East 9th Avenue, Box C-287
Denver, CO 80262
(800) 669-9954

Illness, Injury, and Disease

Alzheimer's Disease and Related Disorders Association
919 North Michigan Avenue, Suite 1000
Chicago, IL 60611-1676
(800) 272-3900
(312) 335-8700

American Academy of Allergy, Asthma and Immunology
611 East Wells Street
Milwaukee, WI 53202
(800) 822-2762 (referral)

American Academy of Dermatology
930 North Meacham Road
P.O. Box 4014
Schaumburg, IL 60173
(847) 330-0230

American Anorexic and Bulimic Association
133 Cedar Lane
Teaneck, NJ 10616
(201) 836-1800

American Association of Blood Banks
8101 Glenbrook Road
Bethesda, MD 20814
(301) 907-6977

American Association of Cardiovascular and Pulmonary Rehabilitation
7611 Elmwood Avenue, Suite 201
Middleton, WI 53562
(608) 831-6989

American Diabetes Association
1660 Duke Street
Alexandria, VA 22314
(800) 232-3472
www.diabetes.org

American Liver Foundation
1425 Pompton Avenue
Cedar Grove, NJ 07009
(800) 223-0179
(973) 256-2550
Fax: (973) 857-2626

Anorexia Nervosa and Associated Disorders
P.O. Box 7
Highland Park, IL 60035
(312) 831-3438

Aplastic Anemia Foundation of America
P.O. Box 22689
Baltimore, MD 21203
(800) 747-2820

Arthritis Foundation
1330 West Peachtree Street
Atlanta, GA 30309
(404) 872-7100

Asthma and Allergy Foundation of America
1125 15th Street, NW, Suite 502
Washington, DC 20005
(800) 727-8462
(202) 466-7643

Brain Injury Association
105 North Alfred Street
Alexandria, VA 22314
(703) 236-6000
Fax: (703) 236-6001

Celiac Sprue Association USA
P.O. Box 31700
Omaha, NE 68131-0700
(402) 558-0600

Cystic Fibrosis Foundation
6931 Arlington Road
Bethesda, MD 20814
(800) 344-4823
(301) 951-4422

Digestive Disease National Coalition
507 Capitol Court, NE
Washington, DC 20002
(202) 544-7499

Eastcoast-Latex-Allergy-Support-Team and Information Coalition (ELASTIC)
136 Main Street
South Portland, ME 04106
(207) 799-0294

Epilepsy Foundation of America
4351 Garden City Drive, Suite 406
Landover, MD 20785-2267
(301) 459-3700

Eye Bank Association of America
1001 Connecticut Avenue, NW, Suite 601
Washington, DC 20036-5504
(202) 775-4999
Fax: (202) 429-6036

Hemochromatosis Research Foundation
P.O. Box 8569
Albany, NY 12208
(518) 489-0972

Huntington's Disease Society of America
158 West 29th Street, 7th Floor
New York, NY 10001
(800) 345-4372
(212) 242-1968

Latex Allergy Information Service
176 Roosevelt Avenue
Torrington, CT 06790
(860) 482-6869
www.latexallergyhelp.com

Leukemia Society of America
600 Third Avenue
New York, NY 10016
(800) 955-4572
(212) 573-8484

Lupus Foundation of America
1300 Piccard Drive, Suite 200
Rockville, MD 20850
(800) 558-0121
(301) 670-9292

March of Dimes Birth Defect Foundation
1275 Mamaroneck Avenue
White Plains, NY 10605
(914) 428-7100
Fax: (914) 428-8203

Myasthenia Gravis Foundation
222 South Riverside Plaza, Suite 1540
Chicago, IL 60606
(800) 541-5454
(312) 258-0522
Fax: (312) 258-0461

National Alliance for the Mentally Ill
200 North Glebe Road, Suite 1015
Arlington, VA 22203-3754
(800) 950-6264
(703) 524-7600
Fax: (703) 524-9094
E-mail: namiofc@aol.com
www.nami.org

National Asthma Education and Prevention Program Information Center
P.O. Box 30105
Bethesda, MD 20824-0105
(301) 251-1222
Fax: (301) 251-1223

National Cancer Institute
Building 31, Room 10A03
31 Center Drive
Bethesda, MD 20892
(301) 496-6667
www.nci.nih.gov

National Chronic Fatigue Syndrome Awareness Association
3521 Broadway, Suite 222
Kansas City, MO 64111
(816) 931-4777
Calls are taken by patient volunteers
and are returned only as collect calls.

National Hemophilia Foundation
116 West 32nd Street, 11th Floor
New York, NY 10001-3112
(800) 424-2634
(212) 328-3700

National Institute of Mental Health
Parklawn Building, Room 15C-05
5600 Fishers Lane
Rockville, MD 20857
(301) 443-4513
www.himh.nih.gov

National Kidney Foundation
30 East 33rd Street
New York, NY 10016
(800) 622-9010
(212) 889-2210

National Mental Health Association
1021 Prince Street
Alexandria, VA 22314-2971
(800) 969-6642
(703) 684-7722
Fax: (703) 684-5968
E-mail: nmhainfo@aol.com
www.worldcorp.com/dc-online/nmha

National Neurofibromatosis Foundation
95 Pine Street, 16th Floor
New York, NY 10005
(212) 344-6633

National Osteoporosis Foundation
1150 17th Street, NW, Suite 500
Washington, DC 20036-4603
(202) 223-2226
www.nof.org

National Resource Center on Homelessness and Mental Illness
262 Delaware Avenue
Delmar, NY 12054
(800) 444-7415
(518) 439-7415
Fax: (518) 439-7612
E-mail: nrc@prainc.com
www.prainc.com/nrc

National School Safety Center
4165 Thousand Oaks Boulevard, Suite 290
Westlake Village, CA 91362
(805) 373-9977
Fax: (805) 373-9277

National Stroke Association
7272 Greenville Avenue
Dallas, TX 75231-4596
(800) 553-6321
E-mail: strokaha@amhart.org
www.stroke.org

National Tuberous Sclerosis Association
8181 Professional Place, Suite 110
Landover, MD 20785
(800) 225-6872
(301) 459-9888

Prader-Willi Syndrome Association
5700 Midnight Pass Road, Suite 6
Sarasota, FL 34242
(800) 926-4797

Research and Training Center for Children's Mental Health
Florida Mental Health Institute
University of South Florida
13301 Bruce B. Downs Boulevard
Tampa, FL 33612-3899
(813) 974-4622
Fax: (813) 974-6257
E-mail: kutash@fmhi.usf.edu
http:\\lumpy.fmhi.usf.edu

Sickle Cell Disease Association of America
200 Corporate Pointe, Suite 495
Culver City, CA 90230-7633
(800) 421-8453

Spina Bifida Association of America
4590 MacArthur Boulevard, NW, Suite 250
Washington, DC 20007
(800) 621-3141
(202) 944-3285

The Federation of Families for Children's Mental Health
1021 Prince Street
Alexandria, VA 22314-2971
(703) 684-7710
Fax: (703) 836-1040
E-mail: ffcmh@crosslink.net

United Scleroderma Foundation
89 Newberry Street
Danvers, MA 01923
(800) 722-4673
(978) 750-4499

Injury Prevention

American Society of Safety Engineers
1800 East Oakton Street
Des Plaines, IL 60018-2187
(847) 699-2929

Aquatic Injury Safety Foundation
1310 Ford Building
Detroit, MI 48226
(800) 342-0330
(313) 963-1600
Fax: (313) 963-1330

Children's Safety Network
Education Development Center
55 Chapel Street
Newton, MA 02158-1060
(617) 969-7100
Fax: (617) 244-3436/527-4096
mch-net: rwbrewer.csn

Children's Safety Network National Injury and Violence Prevention Resource Center
2000 15th Street N, Suite 701
Arlington, VA 22201-2617
(703) 524-7802
Fax: (703) 524-9335
mch-net: csncenter

Children's Safety Network Rural Injury Prevention Resource Center
1000 North Oak Avenue
Marshfield, WI 54449-5790
(715) 389-4999
Fax: (715) 389-4996
mch-net: nfmc.wi

Consumer Product Safety Commission
5401 Westbard Avenue
Washington, DC 20207
(800) 638-2772
www.cpsc.gov

Farm Safety 4 Just Kids
716 Main Street
P.O. Box 458
Earlham, IA 50072
(319) 758-2827

Mothers Against Drunk Drivers (MADD)
511 East John Carpenter Freeway, No. 700
Irving, TX 75062
(214) 744-6233
http://www.madd.org/

National Committee for the Prevention of Child Abuse
332 South Michigan Avenue, Suite 1600
Chicago, IL 60604
(312) 663-3520
Fax: (312) 939-8962
www.childabuse.org/new.html

National Conference of States on Building Codes and Standards
505 Huntmar Park Drive
Herndon, VA 22070
(703) 437-0100

National Fire Protection Association
1 Batterymarch Park
P.O. Box 9101
Quincy, MA 02269-9101
(617) 770-3000
Fax: (617) 770-0700
www.wpi.edul~fpe/nfpa.html

National Lead Information Center
1025 Constitutional Avenue, NW, Suite 1200
Washington, DC 20036-5105
(800) 424-5323

National SAFE KIDS Campaign
National Coalition to Prevent Childhood Injury
1301 Pennsylvania Avenue, NW, Suite 1000
Washington, DC 20004
(202) 662-0600
Fax: (202) 393-2072
www.oclc.org/safekid

National Safety Council
1121 Spring Lake Drive
Itasca, IL 60143
(603) 775-2365
Fax: (603) 285-1315
www.nsc.org

National School Safety Center
4165 Thousand Oaks Boulevard, Suite 290
Westlake Village, CA 91362
(805) 373-9977
Fax: (805) 373-9277

National School Transportation Association
P.O. Box 2639
Springfield, VA 22152
(703) 644-0700

National Student Safety Program
Highway Safety Center
Indiana University of Pennsylvania
Indiana, PA 15705-1092
(412) 357-4051

National Youth Sports Foundation for the Prevention of Athletic Injuries
333 Longwood Avenue, Suite 202
Boston, MA 02115
(617) 277-1171
Fax: (617) 277-2278
E-mail: nyssf@aol.com
www.nyssf.org

Poison Prevention Week Council
P.O. Box 1543
Washington, DC 20013
(301) 504-0580

Students Against Driving Drunk (SADD)
P.O. Box 800
Marlboro, MA 01752
(508) 481-3568
Fax: (508) 481-5759

U.S. Department of Transportation
National Highway Traffic Safety Administration
400 Seventh Street, SW
Washington, DC 20590
(202) 366-5967
www.nhtsa.dot.gov

Nutrition

American Dietetic Association
216 West Jackson Boulevard, Suite 800
Chicago, IL 60606-6995
(312) 899-0040
www.eatright.org

American School Food Service Association
1600 Duke Street, 7th Floor
Alexandria, VA 22314
(800) 877-8822
(703) 739-3900
Fax: (703) 739-3915
www.asfsa.org

Culligan International
One Culligan Parkway
Northbook, IL 60062
(708) 205-6000

U.S. Food and Drug Administration
Rockville, MD 20857
(800) 532-4440
Fax: (301) 443-9767
E-mail: execsec@oc.fda.gov
www.fda.gov

National Committee for World Food Day
2175 K Street, NW, Suite 300
Washington, DC 20437
(202) 653-2404

National Dairy Council
O'Hare International Center
10255 West Higgins Road, Suite 900
Rosemont, IL 60018
(800) 426-8271
Fax: (708) 803-2077

U.S. Department of Agriculture
Food and Nutrition Services
3101 Park Center Drive, Room 609
Alexandria, VA 22302
(703) 305-2554
Fax: (703) 305-2549

Oral Health

American Dental Association
211 East Chicago Avenue
Chicago, IL 60611-2678
(312) 440-2500
Fax: (312) 440-7494
www.ada.org

American Dental Hygienists' Association
444 North Michigan Avenue, Suite 3400
Chicago, IL 60611
(312) 440-8900
www.adha.org/consumer.html

Physical Activity

Bicycle Federation of America
1506 21st Street, NW, Suite 200
Washington, DC 20036
(202) 463-6622
Fax: (202) 463-6625

CDC National Center for Chronic Disease Prevention and Health Promotion
Division of Nutrition and Physical Activity
48 Gilbert Street North
Tinton Falls, NJ 07701
(800) 232-4674
Fax: (908) 530-5848
http://www.cdc.gov/nccdphp/sgr/sgr.htm

Dr. Scholl's
303 East Wacker Drive, Suite 1214
Chicago, IL 60601
(312) 856-8826

League of American Bicyclists
1612 K Street, NW, Suite 401
Washington, DC 20006
(202) 822-1333

National Association for Sport and Physical Education
1900 Association Drive
Reston, VA 20191
(703) 476-3410

National Association of Governors' Councils on Physical Fitness and Sports
201 South Capitol Avenue, Suite 560
Indianapolis, IN 46225-1072
(317) 237-5630

National Running and Fitness Association
4405 East-West Highway, Suite 405
Bethesda, MD 20897-1420
(301) 913-9517

President's Council on Physical Fitness and Sports
200 Independence Avenue, SW, Suite 738H
Washington, DC 20201
(800) 258-8146
(202) 690-9000
Fax: (202) 504-2064
www.dhhs.gov/progorg/ophs/pcpfs.htm

Women's Sports Foundation
Eisenhower Park
East Meadow, NY 11554
(516) 542-4700

Suicide

American Association of Suicidology
4201 Connecticut Avenue, NW
Washington, DC 20008
(202) 237-2280

Worksite Health Promotion

Employe Benefit Research Institute
2121 K Street, NW, Suite 600
Washington, DC 20037
(202) 659-0670
Fax: (202) 775-6312

National Heart, Lung and Blood Institute Information Center
4733 Bethesda Avenue, Room 530
Bethesda, MD 20814
(301) 251-1222
www.nhlbi.nih.gov/nhlbi.htm

Office of Disease Prevention and Health Promotion
National Health Information Center
P.O. Box 1133
Washington, DC 20001
(800) 336-4797
odphp.osophs.dhhs.gov

Washington Business Group on Health
777 North Capitol Street, Suite 800
Washington, DC 20002
(202) 408-9320
(202) 408-9333 (TDD)
Fax: (202) 408-9332

Wellness Councils of America
Community Health Plaza
7101 Newport Avenue, Suite 311
Omaha, NE 68152-2175
(402) 572-3590
Fax: (402) 572-3594

State Resources

General

American Academy of Pediatrics-Wisconsin Chapter
4601 Wallace Avenue
Monona, WI 53716
(608) 222-7751
Fax: (608) 222-7751
E-mail: cme wcaap@aol.com

American Cancer Society
P.O. Box 902
Pewaukee, WI 53072-0902
(414) 523-5500, ext. 103
http://www. cancer. org

American Heart Association
795 North Van Buren
Milwaukee, WI 53202-3883
(800) 242-9236
(414) 271-9999

American Lung Association
150 South Sunnyslope Road, Suite 105
Brookfield, WI 53005-6461
(800) 242-5160
(414) 782-7833

Association of Wisconsin School Administrators
4797 Hayes Road, Suite 1
Madison, WI 53704
(608) 241-0300

Birth to Three Program
Department of Health and Family Services
Division of Community Services
P.O. Box 7851
Madison, WI 53707-7851
(608) 267-3270

Commissioner of Insurance
121 East Wilson Street, 1st Floor
P.O. Box 7873
Madison, WI 53707-7873
(608) 266-3585
Fax: (608) 266-9935

Department of Public Instruction
Division for Learning Support:
Equity and Advocacy
125 South Webster Street
P.O. Box 7841
Madison, WI 53707-7841
(800) 441-4563
(608) 266-1649
(608) 267-2427 (TDD)
www.dpi.state.wi.us/dpi/dicl/lbstat/ed/wi.html

Katie Beckett Program
Department of Health and Family Services
Division of Community Services
P.O. Box 7851
Madison, WI 53707-7851
(608) 266-9590

Prevent Blindness-Wisconsin
759 North Milwaukee Street
Milwaukee, WI 53202
(414) 765-0505
Fax: (414) 765-0377

Wisconsin Association for Supervision and Curriculum Development
Wausau School District
415 Seymour Street
Wausau, WI 54403-6267
(715) 261-2561

Wisconsin Association for Middle Level Education
5839 Woodland Drive
Waunakee, WI 53597
(608) 849-4888

Wisconsin Association of Family and Children's Agencies
131 West Wilson Street, Suite 901
Madison, WI 53703
(608) 257-5939

Wisconsin Association of Nonpublic Schools
30 West Mifflin Street, Suite 302
Madison, WI 53703
(608) 257-0004

Wisconsin Association of Pediatric Nurse Associates and Practitioners
5305 South Hill Drive
Madison, WI 53705
(608) 233-8618

Wisconsin Association of School Boards
122 West Washington Avenue, Suite 400
Madison, WI 53703
(608) 257-2622
Fax: (608) 257-8386

Wisconsin Association of School District Administrators
4797 Hayes Road
Madison, WI 53704
(608) 242-1090
Fax: (608) 242-1290

Wisconsin Association of School Nurses
c/o Jean Nicolet High School
6701 North Jean Nicolet
Glendale, WI 53217
(414) 351-7574 (mornings only)

Wisconsin Congress of Parents and Teachers
4797 Hayes Road, Suite 2
Madison, WI 53704-3256
(608) 244-1455

BEST COPY AVAILABLE

Wisconsin Department of Commerce
201 West Washington Avenue
P.O. Box 7970
Madison, WI 53707-7970
(608) 266-1018

Wisconsin Department of Health and Family Services
1 West Wilson Street
Madison, WI 53703
(608) 266-3442

Wisconsin Department of Regulation and Licensing
Board of Nursing
1400 East Washington Avenue
Madison, WI 53708
(608) 267-2357 (Practice Issues)
(608) 266-0145 (Renewal Issues)
Fax: (608) 267-0644

Wisconsin Education Association Council
33 Nob Hill Drive
Madison, WI 53713
(608) 276-7711
Fax: (608) 276-8203
www.weac.org

Wisconsin Federation of Pupil Services Associations
2430 North Grandview Boulevard
Waukesha, WI 53188
(414) 542-5333

Wisconsin Federation of Teachers
1334 Applegate Road
Madison, WI 53713-3184
(800) 362-7390
(608) 277-7700
Fax: (608) 277-7708

Wisconsin Ethics Committee Network
8701 Watertown Plank Road
P.O. Box 26509
Milwaukee, WI 53226-0509
(414) 456-8498

Wisconsin Nurses Association
6117 Monona Drive
Madison, WI 53716
(608) 221-0383
Fax: (608) 221-2788
E-mail: wna@execpc.com
http://www.execpc.com/~wna

Wisconsin Positive Youth Development Initiative
P.O. Box 490
Plainfield, WI 54966
(715) 335-6100

Wisconsin Prevention Network
711 West Capitol Drive, Suite 210
Milwaukee, WI 53206
(414) 264-2660

Wisconsin Public Health Association
P.O. Box 1109
Madison, WI 53701
(800) 545-0635

Wisconsin School Bus Association
1015 Erie Avenue
P.O. Box 168
Sheboygan, WI 53082-0168
(920) 457-7008

Wisconsin School Counselor Association
4175 County W
DePere, WI 54115
(920) 336-0160

Wisconsin School Psychologists Association
2430 North Grandview Boulevard
Waukesha, WI 53188
(414) 542-5333
http://www.execpc.com/~wspa

Wisconsin School Social Workers Association
2314 East Newton Avenue
Shorewood, WI 53211-2616

Wisconsin Speech-Language-Hearing Association
P.O. Box 1109
Madison, WI 53701-1109
(800) 545-0640
(608) 283-5489

Wisconsin State Legislature
State Capitol
Madison, WI 53703
Legislative Hotline:
(800) 362-9472
(800) 228-2115 (TTY)
www.legis.state.wi.us

Wisconsin State Medical Society
330 East Lakeside
Madison, WI 53715
(608) 257-6781

Wisconsin Women's Council
16 North Carroll Street, Suite 720
Madison, WI 53702
(608) 266-2219

Adolescent Sexuality, Pregnancy, and Parenting

Adolescent Pregnancy Prevention Services Board
16 North Carroll Street, Suite 720
Madison, WI 53703
(608) 267-2080

Healthy Start Program
Pregnancy Outreach Statewide
Department of Health and Family Services
Bureau of Public Health
1414 East Washington Avenue
Madison, WI 53703
(608) 267-9188

Wisconsin Head Start Association
1052 Main Street
Stevens Point, WI 54481
(608) 265-9422

Alcohol and Other Drugs

The Alliance for a Drug-Free Wisconsin
1 West Wilson Street
Madison, WI 53703
(608) 266-9923

Mental Health of Dane County
645 West Washington Avenue
Madison, WI 53703
(608) 280-2700

Wisconsin Association on Alcohol and Other Drug Abuse
6441 Enterprise Lane, Suite 110
Madison, WI 53719
(608) 276-3402

Wisconsin Clearinghouse-Prevention Resource Center for Alcohol and Other Drugs
1552 University Avenue
Madison, WI 53705
(800) 322-1468
(608) 263-2797
Fax: (608) 262-6346

Wisconsin Department of Transportation
Bureau for Transportation Safety
Alcohol Countermeasures and
Youth Alcohol Programs
P.O. Box 7936
Madison, WI 53707-7936
(608) 267-4475

Child Abuse

Children's Trust Fund
Child Abuse and Neglect Prevention Boards
110 East Main Street, Room 614
Madison, WI 53703
(608) 266-6871
Fax: (608) 266-3792

Wisconsin Committee to Prevent Child Abuse
214 North Hamilton Street
Madison, WI 53703
(608) 251-3428

Children with Special Health Needs

ABC for Health
152 West Johnson Street, Suite 206
Madison, WI 53703
(800) 585-4222
(608) 261-6939

Association for Retarded Citizens
121 South Hancock Street
Madison, WI 53703
(608) 251-9272

Autism Society of Wisconsin
103 West College Avenue, Suite 601
Appleton, WI 54911
(888) 428-8476
(920) 993-0279

Camp Heartland
3326 East Layton Avenue
Cudahy, WI 53110
(800) 724-4673
(414) 744-1118
Fax: (414) 744-3844
http://www.digital.com/info/camp

Council on Developmental Disabilities
600 Williamson Street
P.O. Box 7851
Madison, WI 53707-7851
(608) 266-7826

Easter Seal Society of Wisconsin
101 Nob Hill Road, Suite 301
Madison, WI 53713
(608) 277-8288

Easter Seal Society of Milwaukee County
3090 North 53rd Street
Milwaukee, WI 53210
(414) 449-4444

Families Forward
201 Capital Street
Wisconsin Dells, WI 53965-1708
(608) 254-6791

Learning Disabilities Association of Wisconsin
1821 Eagle Drive
Neenah, WI 54956
(920) 727-4636

Mothers United for Moral Support
150 Custer Court
Green Bay, WI 54301-1243
(920) 336-5333
Fax: (920) 339-0995

Parent Education Project
2192 South 60th Street
West Allis, WI 53219-1568
(800) 231-8382
(414) 328-5520
(414) 328-5525 (TDD)
Fax: (414) 328-5530

School-Based Medicaid Services
Department of Health and Family Services
Bureau of Health Care Financing
P.O. Box 309
Madison, WI 53701-0309
(608) 266-0511

Very Special Arts-Wisconsin
4785 Hayes Road
Madison, WI 53704
(608) 241-2131

Volunteer Braillists and Tapists
517 North Segoe Road, #200
Madison, WI 53705
(608) 233-0222
(Tues.-Fri., 8:00 a.m. - Noon)

Wisconsin Association for the Deaf
8142 Beechwood Avenue
Milwaukee, WI 53223
(414) 358-0668 (TDD only)

Wisconsin Association for the Deaf
3839 Highway 22
Rio, WI 53960
(414) 992-5386 (Voice, TDD)

Wisconsin Badger Camp
Summer Address
Rural Route 2
P.O. Box 351
Prairie du Chien, WI 53821
(608) 988-4558

Winter Address
P. O. Box 240
Platteville, WI 53818
(608) 348-9689

Wisconsin Coalition for Advocacy
16 North Carroll Street, Suite 400
Madison, WI 53703
(608) 267-0214

Wisconsin Council of the Blind
354 West Main Street
Madison, WI 53703
(800) 783-5213
(608) 255-1166

Wisconsin Department of Health and Family Services
Division of Children and Family Services
P.O. Box 7851
Madison, WI 53707-7851
(608) 267-9840 (Brain Injury)
(608) 266-7469 (Family Support)

Wisconsin Department of Health and Family Services-Division of Care and Treatment Facilities
Central Wisconsin Center for the Developmentally Disabled
Library Information Center
317 Knutson Drive
Madison, WI 53704
(608) 243-7327

Wisconsin Department of Health and Family Services-Division of Health
Bureau of Public Health
Maternal and Child Health Section
1414 East Washington Avenue, Room 167
Madison, WI 53703-3044
(608) 266-8904
Fax: (608) 267-3824

Program for Children with
Special Health Care Needs
1414 East Washington Avenue
Madison, WI 53703
(800) 441-4576

Wisconsin Department of Health and Family Services-Office for the Hearing Impaired
1 West Wilson Street
P.O. Box 7852
Madison, WI 53707-7852
(608) 266-8081
(608) 266-8082 (TTY)

Regional Offices

Southern Regional Office (Region I)
5005 University Avenue
Madison, WI 53705
(608) 267-3800 (Voice, TTY)
(608) 267-4329 (TTY)

Southeastern Regional Office (Region II)
141 Northwest Barstow
P.O. Box 1349
Waukesha, WI 53187-1349
(414) 521-5128
(414) 548-5858 (TTY)

Milwaukee Regional Office (Region III)
555 West Layton Avenue, #430
Milwaukee, WI 53207
(414) 769-5726 (Voice)
(414) 769-5708 (TTY)

Eastern Regional Office (Region IV)
200 North Jefferson Street, Suite 311
Green Bay, WI 54301
(920) 448-5294 (Voice, TTY)
(920) 448-5295 (Voice, TTY)

Western Regional Office (Region V)
517 East Clairemont Avenue
Eau Claire, WI 54701
(715) 836-2062 (Voice, TTY)
(715) 836-2075 (Voice, TTY)

Northern Regional Office (Region VI)
2416 Stewart Square
Wausau, WI 54401
(715) 842-1211 (Voice, TTY)
(715) 845-5554 (TTY)

Wisconsin Division of Vocational Rehabilitation
Client Assistance Program
1 West Wilson Street, Room 558
P.O. Box 7850
Madison, WI 53707-7850
(800) 362-1290 (Voice, TDD - Wisconsin other
than Dane County)
(608) 267-7422
(608) 267-5016 (TDD)

Wisconsin Family Ties
16 North Carroll Street, #640
Madison, WI 53703
(800) 422-7145
(608) 267-6888

Wisconsin First Step Project
c/o Council on Developmental Disabilities
(800) 642-7837
(800) 282-1663 (TDD)
(608) 266-5148 in the Madison area

Wisconsin Head Start-Resource Assessment Project
Cooperative Educational Service Agency 5
626 East Slifer Street
Portage, WI 53901
(608) 742-8811, ext. 233

Wisconsin Lion's Camp
46 County A
Rosholt, WI 54473
(715) 677-4761

Wisconsin School for the Deaf and Educational Services Center for the Hearing Impaired
309 West Walworth Avenue
Delavan, WI 53115
(414) 728-7116
Fax: (414) 728-7160

Wisconsin School for the Visually Handicappedand Educational Services Center for the Visually Impaired
1700 West State Street
Janesville, WI 53546
(608) 758-6145
Fax: (608) 758-6161

Wisconsin Special Olympics
5900 Monona Drive, Suite 301
Madison, WI 53716
(608) 222-1324
Fax: (608) 222-3578

Division of Care and Treatment Facilities

Child Care Information Center
Wisconsin Reference and Loan Library
2109 South Stoughton Road
Madison, WI 53716
(608) 224-5388

Waisman Center on Mental Retardation and Human Development
University of Wisconsin-Madison
1500 Highland Avenue
Madison, WI 53705-2280
(608) 263-5776

Communicable Diseases

Wisconsin Immunization Program
Department of Health and Family Services
Bureau of Public Health
1414 East Washington Avenue, Room 167
Madison, WI 53703-3044
(608) 266-1339

*Also contact your local health department

Emergency Medical Services

American Heart Association–Wisconsin Chapter
4703 Monona Drive
Madison, WI 53716
(608) 221-8866

American Red Cross–Wisconsin Chapter
4860 Sheboygan Avenue
P.O. Box 5905
Madison, WI 53705-0905
(608) 233-9300

Wisconsin Department of Health and Family Services
1414 East Washington Avenue, Room 227
Madison, WI 53703-3044
(608) 266-9781

Health Education

Wisconsin Association for Health, Physical Education, Recreation and Dance
University of Wisconsin-La Crosse
24 Mitchell Hall
1725 State Street
LaCrosse, WI 54601-3788
(800) 441-4568
(608) 785-8175

Wisconsin Department of Public Instruction
125 South Webster Street
P.O. Box 7841
Madison, WI 53707-7841
(800) 441-4563
(608) 266-3390
(608) 267-2427 (TDD)
Fax: (608) 267-1052
www.dpi.state.wi.us

Illness, Injury, and Disease

American Academy of Allergy and Immunology
611 Wells Street
Milwaukee, WI 53202
(800) 822-2762

Brain Injury Association of Wisconsin
3505 North 124th Street, Suite 100
Brookfield, WI 53005
(414) 790-6901

Children with Attention Deficit Disorder
625 Shoreline Court
Eau Claire, WI 54703
(715) 834-9781

Epilepsy Center South Central
7818 Big Sky Drive, Suite 117
Madison, WI 53719-4983
(800) 657-4929
(608) 833-8888
Fax: (608) 833-6677

Great Lakes Hemophilia Foundation
8739 Watertown Plank Road
P.O. Box 13127
Wauwautosa, WI 53213-0127
(414) 257-0200

Muscular Dystrophy Association
421 South Military Avenue
Green Bay, WI 54303
920) 499-0564

2744 Agriculture Drive
Madison, WI 53718
(608) 222-3269

2949 Mayfair Road, Suite 104
Wauwatosa, WI 53222
(414) 476-9700

National Spinal Cord Injury Association
Madison Chapter
P.O. Box 2685
Madison, WI 53701
(608) 222-8302

Greater Milwaukee Chapter
1545 South Layton Boulevard, Room 516
Milwaukee, WI 53215
(414) 384-4022

Northern Area
2836 Angela Street
Chippewa Falls, WI 54729
(715) 726-1114

Pediatric Pulmonary Center
University ofWisconsin-Madison
Children's Hospital and Clinics
Room H4 - 430
600 Highland Avenue
Madison, WI 53792
(800) 824-8924
(608) 263-8555

Spina Bifida Association
Northeastern Wisconsin
2603 Elm Avenue
Sheboygan, WI 53081
(920) 457-0108

Northern Wisconsin
308 Acorn Street
Stevens Point, WI 54481
(715) 341-6554

Southeastern Wisconsin
P.O. Box 303
Germantown, WI 53022
(414) 963-9905

Greater Fox Valley
500 East Roosevelt
Appleton, WI 54911
(920) 733-3381

Tourette Syndrome Association-Wisconsin Chapter
2512 North Division
Appleton, WI 54911
(920) 739-9872

Tuberous Sclerosis Association
State Representative
N3998 Vista Road
Sullivan, WI 53178
(414) 593-2191

United Cerebral Palsy of Greater Dane County
1502 Greenway Cross
Madison, WI 53713
(608) 273-4434

United Cerebral Palsy of Wisconsin
c/o UCP of South Central Wisconsin
514 North Palm
Janesville, WI 53545
(800) 924-6218
(608) 752-5737

Wisconsin Epilepsy Association
6400 Gisholt Drive, Suite 113
Madison, WI 53713
(608) 221-1210

Wisconsin HIV Primary Care Support Network
Medical College of Wisconsin
Department of Pediatrics
8701 Watertown Plank Road
Milwaukee, WI 53226
(414) 456-4122

Injury Prevention

Wisconsin Department of Health and Family Services
Bureau of Public Health
Injury Prevention Program
1414 East Washington Avenue
Madison, WI 53703-3044
(608) 267-7174
Fax: (608) 261-6392

Wisconsin Department of Transportation
Office of Traffic Safety
4802 Sheboygan Avenue, Room 809
Madison, WI 53707
(608) 266-0402
Fax: (608) 267-0441

Wisconsin Department of Natural Resources
101 South Webster Street
P.O. Box 7921
Madison, WI 53707-7921
(608) 266-2621
Fax: (608) 267-3579

Nutrition

Cooperative Extension Publications
630 West Mifflin Street, Room 170
Madison, WI 53715
(608) 262-3346

Dairy Council of Wisconsin
8418 Excelsior Drive
Madison, WI 53717
(608) 831-1050

University of Wisconsin- Extension
273 Nutritional Sciences Building
Madison, WI 53706-0001
(608) 262-5860

Wisconsin Department of Health and Family Services
5-A-Day for Better Health
1414 East Washington Avenue
Madison, WI 53701
(608) 266-2003

Wisconsin Department of Health and Family Services
Maternal and Child Health
1414 East Washington Avenue, Room 167
Madison, WI 53703-3044
(608) 266-2003
Fax: (608) 267-3824
E-mail: kubitgke@dhfs.state.wi.us

Wisconsin Department of Public Instruction
Child Nutrition Programs
125 South Webster Street
P.O. Box 7841
Madison, WI 53706-7841
(800) 441-4563
(608) 267-9228
Fax: (608) 267-0363

Nutrition Education and Training Program
(608) 267-9120

Wisconsin Dietetic Association
1411 West Montgomery Street
Sparta, WI 54656-1003
(888) 232-8631
(608) 269-0042
Fax: (608) 269-0043
E-mail: wda@centuryinter.net

Wisconsin School Food Service Association
N78 W14573 Appleton Avenue, #196
Menomonee Falls, WI 53051
(414) 251-8668
Fax: (414) 251-5595

Wisconsin Women, Infants, and Children (WIC) Program
1414 East Washington Avenue, Room 167
Madison, WI 53703
(608) 261-6381
Fax: (608) 266-3125

Supplemental Program
(608) 267-7320

Oral Health

Wisconsin Dental Association
111 East Wisconsin Avenue, Suite 1300
Milwaukee, WI 53202
(414) 276-4520
Fax: (414) 276-8431

Wisconsin Department of Health and Family Services
Division of Health
Bureau of Public Health
Maternal and Child Health Section
1414 East Washington Avenue, Room 96
Madison, WI 53703-3044
(608) 266-5152
Fax: (608) 267-3824

Physical Activity

Governor's Council on Physical Fitness and Health
P.O. Box 7841
Madison, WI 53707-7841
(608) 266-1212 (Governor's Office)
(608) 266-7032 (DPI)

Wisconsin Independent Schools Athletic Association
205 Fifth Avenue South, Suite 324
P.O. Box 325
La Crosse, WI 54602-0325
(608) 784-2400

Wisconsin Interscholastic Athletic Association
41 Park Ridge Drive
P.O. Box 267
Stevens Point, WI 54481
(715) 344-8580

Wisconsin Association for Health, Physical Education, Recreation and Dance
University of Wisconsin-La Crosse
24 Mitchell Hall
1725 State Street
La Crosse, WI 54601-3788
(800) 441-4568
(608) 785-8175

Professional Training

School Nursing

Marquette University
615 North 11th Street
Milwaukee, WI 53233
(414) 288-7223
Fax: (414) 288-3945

University of Wisconsin-Eau Claire
Park and Garfield Avenues
Eau Claire, WI 54702-4004
(715)-836-2326
Fax: (715) 836-3245

University of Wisconsin-Madison
500 Lincoln Drive
Madison, WI 53706
(608) 262-9946
Fax: (608) 265-3284

University of Wisconsin-Milwaukee
P.O. Box 413
Milwaukee, WI 53201
(414) 229-4725
Fax: (414) 229-4705

University of Wisconsin-Oshkosh
800 Algoma Boulevard
Oshkosh, WI 54901
(920) 424-1234
Fax: (920) 424-0858

Suicide

Alliance for Mentally Ill
2059 Atwood Avenue
Madison, WI 53704
(608) 249-7188
Fax: (608) 249-7186

Mental Health of Dane County
P.O. Box 1409
Madison, WI 53701-1409
(608) 280-2700

Worksite Health Promotion

Wellness Council of Southeastern Wisconsin
1442 North Farwell Avenue, Suite 300
Milwaukee, WI 53202
(414) 291-9355

Regional Resources

U.S. Department of Education Office of Civil Rights
111 North Canal Street
Suite 1053
Chicago, IL 60606
(312) 886-8434
(312) 353-2546 (TDD)

Cooperative Educational Service Agencies (CESAs)

CESA 1
2930 South Root River Parkway
West Allis, WI 53227
(414) 546-3000
Fax: (414) 546-3095

CESA 2
430 East High Street
Milton, WI 53563
(608) 758-6232
Fax: (608) 868-4864

CESA 3
P.O. Box 5A
Fennimore, WI 53809-9702
(608) 822-3276
Fax: (608) 822-3828

CESA 4
1855 East Main Street
Onalaska, WI 54650
(608) 785-9364
Fax: (608) 785-9777

CESA 5
626 East Slifer Street
P.O. Box 564
Portage, WI 53901-0564
(608) 742-8811
Fax: (608) 742-2384

CESA 6
2300 State Road 44
P.O. Box 2568
Oshkosh, WI 54903-2568
(920) 233-2372
Fax: (920) 424-3478

CESA 7
595 Baeten Road
Green Bay, WI 54304-5763
(920) 492-5960
Fax: (920) 492-5965

CESA 8
233 West Park Street
P.O. Box 320
Gillett, WI 54124-0320
(920) 855-2114
Fax: (920) 855-2299

CESA 9
328 North 4th Street
P.O. Box 449
Tomahawk, WI 54487-0449
(715) 453-2141
Fax: (715) 453-7519

CESA 10
725 West Park Avenue
Chippewa Falls, WI 54729-3276
(715) 720-2079
Fax: (715) 720-2070

CESA 11
225 Ostermann Drive
Turtle Lake, WI 54889-9011
(715) 986-2020
Fax: (715) 986-2040

CESA 12
618 Beaser Avenue
Ashland, WI 54806-2751
(715) 682-2363
Fax: (715) 682-7244

Wisconsin Department of Health and Family Services Division of Health Regional Offices

Northeastern Regional Office
200 North Jefferson, Suite 126
Green Bay, WI 54301-5182
(414) 448-5220
Fax: (414) 448-5265

Northern Regional Office
1853 North Stevens Street
Rhinelander, WI 54501
(715) 365-2703
Fax: (715) 365-2705

Southeastern Regional Office
819 North 6th Street, Room 860
Milwaukee, WI 53203-1697
(414) 227-4910
Fax: (414) 227-2010

Southern Regional Office
3518 Memorial Drive, Building 4
Madison, WI 53704
(608) 243-2351
Fax: (608) 243-2365

Western Regional Office
312 South Barstow Street, Suite 2
Eau Claire, WI 54701-3679
(715) 836-5362
Fax: (715) 836-6686

Minority Community-Based Organizations (CBOs)

Wisconsin Association of Black Social Workers
4011 West Capital Drive
Milwaukee, WI 53216
(414) 444-7755
Fax: (414) 444-7822

United Migrant Opportunity Services
802 West Mitchell
Milwaukee, WI 53204
(414) 671-5700
Fax: (414) 482-7210

Opportunities Industrialization Center of Racine
1020 Washington Avenue
Racine, WI 53403
(414) 636-3818
Fax: (414) 636-3922

Great Lakes Inter-Tribal Council
P.O. Box 9
Lac du Flambeau, WI 54538
(715) 588-3324
Fax: (715) 588-7900

Urban League of Greater Madison
151 East Gorham Street
Madison, WI 53703
(608) 251-8550
Fax: (608) 251-0944

Centro Hispano
132 East Mifflin Street
Madison, WI 53703
(608) 255-3018
Fax: (608) 255-2975

AIDS Service Organizations (ASOs)

Wisconsin AIDSline: (800) 334-AIDS
Milwaukee area AIDSline: (800) 273-AIDS

AIDS Resource Centers of Wisconsin
Northeastern Region
824 South Broadway
Green Bay, WI 54304
(800) 675-9400
(920) 437-7400
Fax: (920) 437-1040

120 North Morrison Street, Suite 201
Appleton, WI 54911
(800) 773-2068
(920) 733-2068
Fax: (920) 733-7786

Northern Region
Oneida County Health Department
P.O. Box 400
Rhinelander, WI 54501
(800) 374-7678
(715) 369-6228
Fax: (715) 369-6112

1105 Grand Avenue, Suite 3
Schofield, WI 54476
(715) 355-6867
Fax: (715) 355-7684

Southeastern Region
820 North Plankinton Avenue
Milwaukee, WI 53203
(800) 359-9272
(414) 273-1991
Fax: (414) 273-2357

1212 57th Street
Kenosha, WI 53140
(800) 924-6601
(414) 657-6644
Fax: (414) 657-6949

Southern Region
600 Williamson Street
Madison, WI 53703
(800) 486-6276
(608) 252-6540
Fax: (608) 252-6559

32 South Main Street
Janesville, WI 53545
(800) 486-6276
(608) 756-2550
Fax: (608) 756-2545

159 West Grand Avenue
Beloit, WI 53511
(800) 486-6276
(608) 363-8674

Western Region
505 South Dewey Street, Suite 107
Eau Claire, WI 54701
(800) 750-2437
(715) 836-7710
Fax: (715) 836-9844

Grandview Center
1707 Main Street, Suite 420
LaCrosse, WI 54601
(608) 785-9866
Fax: (608) 784-6661

Board of Trade
1507 Tower Avenue, Suite 230
Superior, WI 54880
(715) 394-4009
Fax: (715) 394-4066

Tribal Education Organizations

Bad River Education
P.O. Box 39
Odanah, WI 54861
(715) 682-7111
Fax: (715) 682-7118

Forest County Potawatomi Education
P.O. Box 340
Crandon, WI 54520
(715) 478-2903
Fax: (715) 478-7293

Lac du Flambeau Education
P.O. Box 67
Lac du Flambeau, WI 54501
(715) 588-3303
Fax: (715) 588-7930

Lac Courte Oreilles Education
Route 2, Box 2700
Hayward, WI 54843
(715) 634-8934
Fax: (715) 634-4797

Menominee Indian Education
P.O. Box 910
Keshena, WI 54135
(715) 799-5114
Fax: (715) 799-3373

Oneida Education and Training
P.O. Box 365
Oneida, WI 54155
(920) 869-4374
Fax: (920) 869-4040

Red Cliff Education
P.O. Box 529
Bayfield, WI 54814
(715) 779-3700
Fax: (715) 779-3704

St. Croix Education
P.O. Box 287
Hertel, WI 54845
(715) 349-2195, ext. 101
Fax: (715) 349-5768

Sokaogon Chippewa Community
Route 1, Box 625
Crandon, WI 54520
(715) 478-2604
Fax. (715) 478-5275

Stockbridge-Munsee Education
N8476 Moheconuck Road
Bowler, WI 54416
(715) 793-4111
Fax: (715) 793-1307

Wisconsin Ho-Chunk Education
P.O. Box 667
Black River Falls, WI 54615
(800) 361-4476
Fax: (715) 284-9805

Internet Discussion Groups

AJN Forum for School Nurses
http://www.ajn.org/people/page1.cfm

CSHCN-L
Children with Special Health Care Needs
LISTSERV@LISTS.UFL.EDU

KML (Kids mental health)
KML-list-request@affinitybooks.com

NRSING-L
Nursing Informatic List
listserv@listserv.utoronto.ca

PHNURSES
Public Health Nurses
listproc@u.washington.edu

SBHCNET
School Based Health Center List
SBHCNET request@HERMES.CIRC.GWU.EDU

SCHRN-L
School Nurse List
listserv@listserv.acsu.buffalo.edu

UCLC Center for Mental Health in Schools
maiser@bulletin.psych.ucla.edu

Other Nursing Resources

Bandaids and Blackboards—
When Chronic Illness...Or Some Other Medical Problem...Goes to School
http://funrsc.fairfield.edu:80/~jfleitas/contents.html

Children's Policy
http://www.kidscampaigns.org/Connect/linkspolicy.html

Healthgate
Health, Wellness, and Biomedical Information (Medline)
http://www.healthgate.com/

Intelihealth—
John Hopkins Health Information
http://www.InteliHealth.com

Kids Health
http://KidsHealth.org/

Nurse Practitioner Home Page
http://www.npweb.org/

Pharmaceutical Information Network
http://www.pharminfo.com/

Public Health Service
http://phs.os.dhhs.gov/phs/phs.html

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Chapter 1

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Appendixes

14

A. *School Nurse Position Description*

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Appendix A

School Nurse Position Description

Responsibilities

The school nurse is responsible for carrying out the school district's health program, as defined by Wisconsin state statutes, administrative rules, district policies, and consistent with the Wisconsin Nurse Practice Act. The goals of the position are to maintain and/or improve the health status of students, thus enabling them to benefit from their educational experiences, and to promote optimum health status and lifestyles for all students through the joint efforts of the home, school, and community.

Qualifications

1) Licensed professional registered nurse in Wisconsin
2) Bachelor's degree in nursing
3) Certification as school nurse by Wisconsin Department of Public Instruction
4) Successful annual completion of CPR protocol

Work Performed

1) Applies appropriate nursing theory as the basis for decision making in the school setting.
    a) examines basic assumptions of the nursing theories related to school practice.
    b) refines content of belief system and integrates new theories.
    c) applies relevant theories as basis for measurable objectives and relevant interventions for the student, family, and school personnel.
    d) shares theoretical information with peers, students, family, other professionals, and the community to assist change.
2) Establishes and maintains a coordinated school health program following the guidelines set forth in Wisconsin state statutes, regulations, and school district policy.
    a) consults with school administrators to establish, review, and revise policy and procedures for a comprehensive school health program.
    b) determines the delegation of health care procedures to paraprofessionals, the extent of their orientation, and amount and type of ongoing monitoring and supervision that will be needed to comply with state nurse practice act and other legal considerations.
    c) arranges in-service programs for school personnel for first aid, emergency care procedures, and current health issues.
    d) promotes good safety practices, both within and outside of school buildings.
    e) establishes processes to identify students at risk for physical and psycho-social problems and communicates health needs to other school personnel; serves as member of interdisciplinary teaming providing support services to students.
    f) maintains school health records for each student.
    g) prepares reports as required by the district, Wisconsin Department of Public Instruction, and Wisconsin Division of Health.
    h) uses data collected to plan and evaluate the school health program.
    i) collaborates with school administrators and personnel in assessing and improving the social and emotional climate of school and classrooms.
    j) promotes an awareness of the influence of curriculum, policies, activities, communications, and stress levels on the mental health of students and personnel.
    k) involves students in maintaining a healthful school environment.
3) Develops individualized health plans for students using nursing process.
    a) collects information about the health and developmental status of the student in a systematic and continuous manner, including health and social histories; screening results; physical assessment; emotional status; performance level; and health goals.
    b) collects data from student, family, significant others, school personnel, and health care professionals.

c) uses data collected about the health and educational status of the student to determine a nursing diagnosis.
   i) coordinates efforts with those of other providers and school personnel to decrease duplication of care.
   ii) identifies relationship between health status and the students ability to learn.

d) develops a nursing care plan with specific goals and interventions, delineating school nursing actions unique to student needs.

e) intervenes as guided by the nursing care plan to implement nursing actions that promote, maintain, or restore health; prevent illness; and affect rehabilitation.

f) assesses student response to nursing actions in order to revise the data base, nursing diagnoses, and nursing care plan, and to determine progress made toward goal achievement.

g) documents diagnoses, plans, interventions, and results on the student health record.

4) Collaborates with other professionals in assessing, planning, implementing, and evaluating programs and other school health activities.
   a) participates as a team member.
   b) acts as advocate for the student and family when appropriate.
   c) includes the student in the team conference whenever possible and appropriate.
   d) identifies health-related needs and objectives for inclusion in the individual education plan; assumes responsibility for provision of health-related procedures and treatments.
   e) cooperates with other team members and community sources of care to prevent duplication of services.

5) Assists student, families, and groups to achieve optimal levels of wellness through health education.
   a) identifies needs for health education.
   b) serves as resource person for health education classes; and as member of curriculum committee for health education.
   c) counsels students and families in health-related matters.
   d) promotes preventive self-care strategies with school personnel.

6) Participates in peer review and other means of evaluation to assure quality of nursing care provided for students; assumes responsibility for continuing education and professional development.

7) Participates with other members of the community to assess, plan, implement, and evaluate school health services and community services that include the broad continuum of promotion of primary, secondary, and tertiary prevention.
   a) participates in planning for school health services within the community.
   b) provides coordination with existing systems and services.
   c) facilitates the development and implementation of school health services.
   d) influences appropriate individuals and groups regarding school and community health needs.
   e) interprets school health services needs and the role of the school nurse to the school and community.
   f) uses community resources for referral of students with unmet health needs in the school.
   g) collaborates with agencies within and outside of the community to ensure continuity of service and care.

8) Contributes to nursing and school health through innovations in theory and practice and participation in research.
   a) generates relevant questions regarding school nursing practice.
   b) seeks resources for answering research questions.
   c) obtains expert consultation, supervision, and peer review as needed.

Competency Attainment

The school nurse must be able to fulfill the responsibilities of the position at the time of employment.

Delegation and Supervision Given and Received

The school nurse provides supervision to the school health paraprofessional. The school nurse reports to the chief school administrator, or to the person designated by him/her to be responsible for the school health program, and to the building principal. The school nurse works in partnership with the local public health and human services agencies.

School Health Paraprofessional Position Description

Nonprofessional School Health Personnel

I. Special characteristics
   A. Required training and experience
      1. Successful completion of a minimum 24-hour approved school health assistant course within the last year or equivalent as defined by school nurse.
      2. Successful completion of above course or equivalent, as defined by the school nurse every three years.
      3. Maintenance of current certification in CPR and basic first aid.
      4. Experience with school age children.
   B. Special requirements
      1. Adequate physical strength to perform all assigned duties.
      2. Perform basic clerical skills such as filing, recording, tabulating, and general receptionist duties; typing and computer skills preferred.
      3. Ability to develop positive constructive relationships with students, school staff, families, and the public.

II. Working relationships
   A. Reports to school nurse and building principal.
   B. Receives guidance from:
      1. school nurse
      2. program support person(s)
      3. building principal
   C. Extent of guidance received:
      1. Carries out Board of Education (BOE) policies and procedures under the direction and supervision of the school nurse, program support person, and principal.
      2. Receives assignment of daily schedule and routine from the school nurse.

III. A. Assisting the school nurse and/or program support person integrating the district's philosophy on health services into the running and maintaining of the school health office. The primary emphasis is on maintaining an optimal level of health for all students through:
      1. Triage of students due to symptoms of illness.
      2. Providing basic emergency care for illness or injury within established BOE policy and procedures and under the school district health services guidelines.
      3. Referring of emergency situations to parents, physicians, and hospitals within established procedures.
      4. Notifying nurse and appropriate building personnel of any emergency situations.
      5. Monitoring students' health status during periods of short term rest or recovery.
      6. Following all BOE policies and procedures.
      7. Planning and carrying out school health screenings under the direction of the school nurse.
      8. Administering medications as specified in BOE policy and carrying out nursing procedures under the direction and/or delegation, training, and supervision of the nurse. Notify building nurse of all medication orders.
      9. Gathering and recording information on the immunization status of students.

B. Knowing and carrying out district health policies and procedures and keeping accurate and confidential records of contacts with students and/or their families, the nature of health concerns, and the action taken. Also responsible for keeping the school nurse and/or program support person apprised of activities.
C. Ordering, maintaining, and properly storing all necessary supplies and equipment in the health office.
D. Maintaining cleanliness of health office.
E. Performing clerical duties associated with the health office, including data entry.
F. Performing related work as assigned by the building principal.
G. Maintaining good communication with students, parents, classroom teachers, the principal, and the school nurse and/or program support person with whom assigned.
H. Demonstrating a commitment to the school district and its philosophies and goals by attitudes and actions.

Sample District Allocation of School Nurse Hours

Professional school nurse time per building for one week is based on the following criteria:

Enrollment

Base used for allocation: One hour for first 300 students. An additional "theoretical" hour of time is added for every additional 100 students.

Early Childhood (EC) Students and All Day Kindergarten or Any Combination of These

One hour for every 20 EC students.

One hour for every 20 students qualifying for Medical Assistance, Healthy Start, free or reduced lunch or milk, fee waiver.

Mobility

One hour for every 30 students transferred in or out of the school district calculated from school year closing to closing (including incoming kindergartners).

Children with Disabilities without Health Considerations

One hour for every 20 children with disabilities.

Health Considerations Students (physical, mental, or psychological)

One hour for every six students, including planning and monitoring health needs; nursing services during preattendance and attendance; IEP-Team process; health status assessment; staff and assistive personnel inservice, training, monitoring, and supervising; facilities review; and transportation.

Direct Nursing Care

Medically Intensive: One-half hour for each procedure and/or diagnosis per student each school day (or equivalent). Students who require special nursing skills (assessment, procedures, evaluation) daily. Medical problems include the following: ventilator dependence; tracheostomy dependence; oxygen dependence; bronchial or tracheal malacia; nutritional problems requiring hyperalimentation or gastrostomy tube dependence; congestive heart problems; required long-term, high-tech care for post-trauma children; required apnea-monitoring; kidney dialysis; and sudden changes in physical condition. A full-time professional nurse will be on the school campus when a medical act is delegated to the professional school nurse in an emergency situation *or* when a professional nursing assessment deems the delegation of a nursing act is inappropriate.

Medically Complex: One hour for every two students and, on days not present, a trained health assistant may carry out some required procedures. Students who have serious chronic or acute conditions that decrease strength, vitality, or alertness and may, under certain circumstances, be life-threatening; such as students with leukemia, muscular dystrophy, severe cerebral palsy, seizure disorder, asthma, diabetes, anaphylactic response, and so forth.

Medically Limited: One hour for every 10 students. Collaborative consultation team-one hour per building. Students with chronic illnesses that may not be immediately apparent, but which often require more school nursing attention and interpretation for faculty; such as seizure disorders, diabetes, asthma, pregnancy, HIV, and AODA concerns.

Staff

One hour for every 50 staff people.

Source: Prepared by Janice A. Collins, School Health Supervisor, Appleton (WI) Area School District, in consultation with Mary Gulbrandsen, Health Services Coordinator, Madison (WI) Metropolitan School District, November 1990.

School Nursing Roles: Activities, Standards, and Legislation

ROLE: Provider of Student Health Care

Suggested Objectives	Desired Results	Related Standards, Laws, and Policies
Applies appropriate theories of nursing and the physical, behavioral, public health, and social sciences to meet/promote:	Student health needs and their relationship to the educational experience are identified and interventions to prevent, modify, remediate, or remove health-related problems are implemented.	American Nurses Association (ANA) Standards of School Nursing Practice, 1983 ANA Code for Nurses with Interpretive Statements, 1985
• the unique and diverse needs of students and staff in the school community;	Social, cultural, physical, and political diversity are recognized, discussed, and appreciated.	National Association of School Nurses (NASN) Code of Ethics with Interpretive Statements for the School Nurse, 1990
• the objectives of the school health program; and		
• the mission of the educational system.		NASN School Nursing Practice: Roles and Standards, 1993
Using appropriate techniques, collects and documents information regarding students, health-care providers, organizations, and/or the community in a systematic continuous manner.	Student's physical health record and patient health care record, if appropriate, are available and maintained in a confidential manner in the school building.	Family Education Rights and Privacy Act 20 U.S.C. 1232 34 CFR 99 (FERPA) Individuals with Disabilities Education Act 20 U.S.C. 1101-80, Revised 1997 (IDEA-R97)
Analyzes assessment data to derive actual and potential responses to health concerns which can be validated, are documented, and will facilitate the development of a plan of care and acceptable outcomes.	A data system for follow-up of health concerns is identified in the school district.	Section 504 of the Vocational Rehabilitation Act 29 U.S.C. 794, 1973 Americans with Disabilities Act 42 U.S.C. 12002 34-396, 1990 (ADA, 1990)
Documents measurable, appropriate, attainable, and timely goals/outcomes derived from the diagnosis, which have been mutually formulated with the student and/or the family.	Nursing diagnoses are validated with the student/family and school personnel, when appropriate.	Wis. Stat. 441 Nurse Practice Act Wis. Admin. Code PI 3.51 School nurse certification
Develops a plan of care in which nursing interventions are designed to attain mutually formulated, measurable outcomes. This plan is unique to the student or staff member, and progress is documented.	Nursing diagnoses are recorded in a manner which facilitates planning, evaluation and research.	Wis. Stat. 118.125 Pupil records
	Nursing diagnoses are accepted by the school and health community as relevant and significant.	Wis. Stats. 146.81-84 Patient health care records

ROLE: Provider of Student Health Care

Suggested Objectives	Desired Results	Related Standards, Laws, and Policies
	Students, families, and staff members use information provided in making decisions and choices about promoting, maintaining, and restoring health as well as seeking and accessing appropriate health-care personnel and resources.	Wis. Stat. 115.80 Identifying and providing special education to children with exceptional education needs
	The individualized health-care plan is recorded and maintained in a confidential manner for review by those implementing the plan.	Wis. Admin. Code PI 11 Implementing Subchapter V of Wis. Stat. 115 Wis. Stat. 118.13 Pupil nondiscrimination
	The individualized health-care plan shows evidence of mutual review and revision as needs change or goals/outcomes are achieved.	Wis. Stat. 48 Children's Code Wis. Stat. 48.981 Child abuse and neglect
Implements and adequately documents the interventions identified in the plan of care in a safe, appropriate manner.	Students and staff members demonstrate understanding of their health condition and knowledge of self-care skills, consumer skills, and health-care resources.	Wis. Stat. 118.126 Privileged communication Wis. Stat. 118.255 Health treatment services for children with special physical or mental health needs
	Students with compromised health status actively participate in educational activities to the fullest extent possible.	Wis. Stat. 118.24(2)(f) Students with alcohol and other drug problems
Systematically evaluates student responses to prescribed interventions and to the efficacy of interventions in relation to the identified outcomes. Documents and uses evaluation data to revise plan of care, as appropriate.	Individualized health-care plans are revised based on outcomes identified in the evaluation.	Wis. Stat. 118.153 Children at risk Wis. Stat. 118.16 Truancy
	Evaluation of nursing care is recorded in a manner that promotes review and refinement of nursing theory and practice.	Wis. Stat. 252.14-15 AIDS Wis. Stat. 940 Crimes against life and bodily security
Assists in identifying students who may need further evaluation by: • obtaining a health and developmental history from the student and parents,	Collected health and developmental information is reviewed in a holistic manner.	Wis. Stat 948 Crimes against children

ROLE: Provider of Student Health Care

Suggested Objectives	Desired Results	Related Standards, Laws, and Policies
● providing needed health-status screening and inspection,		General Education Provisions Act, 1978
● reviewing the information collected to determine individuals or groups of students actually or potentially at high risk for special-needs services,		Local school district policies
● conferring with parents during a home visit or school conference,		
● assessing family and environmental factors which impact on student's health status,		
● obtaining health-care information from primary health-care providers and community resource agencies in accordance with state law and local school district policies,		
● observing classrooms and peer interactions to determine each student's personal strengths and health needs.	Students with actual or potential health problems receive nursing services, as appropriate.	
● receiving referrals from student-service providers, teachers, and other school staff.	Health status is determined for each student needing specialized nursing procedures.	
Communicates to parents, students, and school personnel the need for regular and special health assessments and interventions.	Significant health information is held in a confidential manner and reported to students, parents, and school personnel within the parameters defined in federal and state law and local school district policy.	
	A current list of school and community resources is available to students, parents, and school personnel.	
	Each student who is experiencing health problems/needs is identified and referred for further evaluation, as appropriate.	

ROLE: Provider of Student Health Care

Suggested Objectives	Desired Results	Related Standards, Laws, and Policies
	Health screening information for students experiencing health problems is provided to students, parents, school personnel, and community health and social service providers to coordinate care.	
	Suspected child abuse and neglect is reported; the student, family, and staff receive support and counseling from an appropriate professional.	
	Individuals with social health problems (drug abuse, sexually transmitted diseases, unprepared pregnancy, and so forth) receive care and support through student- or employee-assistance and other school-community programs.	
Explores resources with parents, students, school personnel, and primary-care providers.	Current list of school and community resources is available to students, parents, and school personnel.	
Intervenes with students and families experiencing actual/ potential health problems and crises.	Each student who is experiencing health problems/needs is identified and referred for further evaluation, as appropriate.	
	Health screening information for students experiencing health problems is provided to students, parents, school personnel, and community health and social service providers to coordinate care.	
	Suspected child abuse and neglect is reported; the student, family, and staff receive support and counseling from an appropriate professional.	
	Individuals with social health problems receive care and support through student or employee-assistance and other school-community programs.	

ROLE: Provider of Student Health Care

Suggested Objectives	Desired Results	Related Standards, Laws, and Policies
Collaborates with others to determine pertinent health factors impacting the educational plan.	Appropriate school personnel, the nurse, and students with special needs and their families participate in planning the educational program (for example, IEPs and accommodation plans). Optimal educational placement of the student is made.	
Develops an individual health plan and recommends related health services be written into the IEP or accommodation plan, including: • a description of needed services, • a statement of the annual goals and periodic objectives, and • a plan for the review of services.	Pertinent health services are identified for students with health needs. Appropriate personnel are employed or services are contracted for to meet the needs of special students. Measurable objectives are written for specified health services.	
Provides direct nursing services as described in the individual health plan, IEP, or accommodation plan.	Health services are provided as stated in the individual health plan, IEP, or accommodation plan.	
Acts as an advocate and liaison among parent(s)/guardian(s), students, school personnel, health-care personnel, and community resources.	Students with health needs discuss health concerns, problem solve as appropriate for their age and developmental stage, and become increasingly responsible for their own care. Health and developmental information is maintained within the parameters defined in federal and state law and local school district policy. Students and/or families follow through on health-related educational recommendations.	

ROLE: Provider of Student Health Care

Suggested Objectives	Desired Results	Related Standards, Laws, and Policies
Acts as a resource person for teachers in planning and presenting effective health education about disabling conditions.	Teacher assumes primary role for classroom teaching and classroom management. Students and teachers are knowledgeable about special health needs and discuss questions on their feelings openly.	
Reviews annually, or as needed, the health status of students with disabilities.	Health-services and educational programs for students with special health needs are evaluated annually or as needed.	
Coordinates with school personnel arrangements for an appropriate environment to meet the needs of students with disabilities, including issues of transportation and adjustment of school equipment and facilities.	Bus drivers, teacher aides, and other school personnel are made aware of students with special health needs. Necessary adaptations/modifications to school facilities are made to provide barrier-free buildings and accommodate students with disabilities.	

ROLE: Communicator

Suggested Objectives	Desired Results	Related Standards, Laws, and Policies
Uses effective expressive and receptive verbal skills and clear, concise written communication.	Ensures that students, families, school administrators, other school personnel, and others, as appropriate, are informed about the current health status of and the interventions taking place within the school setting.	ANA Standards of School Nursing Practice, 1983 ANA Code for Nurses with Interpretive Statements, 1985 NASN Code of Ethics with Interpretive Statements for the School Nurse, 1990 NASN School Nursing Practice: Roles and Standards, 1993 Wis. Stat. 441 Nurse Practice Act
Develops and maintains an effective system of information storage, retrieval, and analysis.	Evidence exists of verbal/written reports which reflect current nursing theory, practice, and/or research.	
Develops and implements systems to communicate regularly with students, parents, school personnel, and others to address health-related education needs.	Meaningful relationships exist among students, school personnel, and community providers.	
	Health-service and health-status information is collected, communicated, and maintained within the parameters defined in federal and state law and local school district policy.	
	Annual health-service and miscellaneous reports are developed and presented to the school administration and others, as appropriate, to provide continuity and accountability for the health-service program.	
	Documentation exists of establishment, review, and revision of school district policies and procedures.	
	Nursing care plans are developed and revised based on the health and behavioral changes identified in the evaluation.	

ROLE: Planner and Coordinator of Student Health Care: Emergency Nursing Services, Communicable Disease, Health Assessment, and School Safety

Suggested Objectives	Desired Results	Related Standards, Laws, and Policies
Communicates the philosophy and/or mission of the school district, the kind and purpose of its curricular and extracurricular activities, and its programs and special services.	Communicates an understanding and facilitates coordination of school and community resources to address student health, developmental and educational needs.	ANA Standards of School Nursing Practice, 1983 ANA Code for Nurses with Interpretive Statements, 1985
With the school administration, recommends and implements the development of school board policies and related procedures for the school health program.	Written health policies that conform to federal and state law and reflect the mission of the school district are in place and accessible to all students, parents, school staff, and community members.	NASN Code of Ethics with Interpretive Statements for the School Nurse, 1990 NASN School Nursing Practice: Roles and Standards, 1993
With the school administration, facilitates the formation of a School Health Committee, which may include administrators, allied-health professionals, teachers, students, parents, and other community residents concerned with the health of children and youth.	The School Health Committee composition reflects school and local community resources.	FERPA, 1974 IDEA-R97 Section 504 of the Vocational Rehabilitation Act, 1973 ADA, 1990
With the School Health Committee, performs assessment of the	School Health Committee meets on a regular basis to review and make recommendations for the total school health program and for meeting the health needs of school-aged children in the community.	Wis. Stat. 441 Nurse Practice Act Wis. Stat. 448 Medical Practice Act
• health needs in the school and community,	Student health records and other collected health data are used (within the context of confidentiality requirements) in interpreting school and student health needs and in program planning.	Wis. Admin. Code PI 3.51 School nurse certification Wis. Stat. 120.13(11)(a)(b) Nurses and dentists
• health needs of students and school staff.	Annual health-service and miscellaneous reports are developed regarding health needs, resources, and results and are presented to the school administration and others, as appropriate, to provide accountability for the health-service program.	Wis. Stat. 101.055 Public employee safety and health (clean indoor air)

ROLE: Planner and Coordinator of Student Health Care: Emergency Nursing Services, Communicable Disease, Health Assessment, and School Safety

Suggested Objectives	Desired Results	Related Standards, Laws, and Policies
• available health resources in the school and community.		Wis. Stats. 121.02 (a)(e)(g)(i) School district standards in (a) staff licensure, (e) guidance and counseling services, (g) emergency nursing services, and (i) safe and healthful facilities
Facilitates appropriate integration of services, instruction, and a healthful environment in an annual school health plan.	Goals and objectives for coordination of the school health program are developed, implemented, reviewed, and revised annually.	
	Program priorities are established to meet the current needs of students and staff.	Wis. Admin. Code PI 8.01 (a), (e), (g), and (i) Rules implementing Wis. Stat. 121.02
Demonstrates leadership in the development of a communications system that includes progress reports and discussions of issues relating to the school health program, supervision, inservice education, and accountability of health-service personnel.	Discussion with administrators and others, as appropriate, regarding the health-service program occurs on a regular basis and as needed.	Wis. Stat. 118.019 Human growth and development
	A health-referral system is established collaboratively within the school and community.	Wis. Stat. 115 Wis. Admin. Code PI 11 implementing Subchapter V of Wis. Stat. 115 Children with exceptional education needs
	Health-service inservices are provided on a regular basis.	
	Records and reports are current; demonstrate cost benefits, when appropriate; and impact on student health, developmental, and educational needs.	Wis. Admin. Code ILHR 32.50 1910.1030 Bloodborne pathogens
		Wis. Stat. 895.48 Civil liability exception; emergency care
Participates in the recruitment, employee orientation, and training of health-service personnel.	Qualified health-service personnel are employed.	Wis. Stat. 118.29 Administration of drugs to pupils and emergency care
Delineates roles and responsibilities of the school nursing supervisor, school nurse, medical advisor, and health-services aide for school staff and adjunct personnel.	School staff are regularly oriented to school health-service programs, activities, and staff.	Wis. Stat. 252.04 Statewide immunization program
		Wis. Stat. 118.25 Employee health exams

ROLE: Planner and Coordinator of Student Health Care: Emergency Nursing Services, Communicable Disease, Health Assessment, and School Safety

Suggested Objectives	Desired Results	Related Standards, Laws, and Policies
	Health-service personnel are oriented, supervised, and periodically evaluated.	Wis. Stat. 252.21 Communicable disease; schools
		Wis. Admin. Code HSS145
		Wis. Stat. 118.07 Safety requirements
Annually identifies needs for school health service budget development.	Health-service resources (supplies, equipment, information) are available.	Wis. Stat. 118.163 Children at risk
	Federal, state, and designated local funds and grant funds are accessible to complement district general funds.	Wis. Stat. 118.126 Privileged communication Wis. Stat. 118.17 Indigent children
Emergency Nursing Services		Wis. Stat. 118.255 Health treatment services for children with special physical or mental health needs
Develops and implements nursing procedures in cooperation with the medical advisor, administrators, school personnel, and parents.	Nursing procedures are written and distributed to appropriate persons.	Wis. Stat. 118.24(2)(f) Students with alcohol and other drug problems
Assesses the need for first aid and medication-administration equipment and supplies.	Local emergency phone numbers are posted near school phones.	Wis. Stat. 118.15 Compulsory school attendance
Informs students, parents, and school personnel of emergency-care and medication-administration policies and procedures.	Transportation of ill or injured students and school personnel is arranged according to written school district policies and procedures.	Wis. Stat. 118.16 Truancy Wis. Stat. 48 Children's Code
Assists with development of first aid, CPR, and medication-administration instruction and inservices for school staff.	Information for notifying families of emergency situations is available.	Wis. Stat. 48.981 Child abuse and neglect reporting
Provides for emergency-care and medication-administration needs of students and school personnel.	Facilities, supplies, and equipment are available.	Wis. Stat. 115.362 Youth alcohol and other drug abuse programs

ROLE: Planner and Coordinator of Student Health Care: Emergency Nursing Services, Communicable Disease, Health Assessment, and School Safety

Suggested Objectives	Desired Results	Related Standards, Laws, and Policies
Recognizes crisis situations and intervenes to aid in resolving the crisis.	Students, parents, and school personnel are knowledgeable about the school's role in administering nursing care, first aid, emergency care, and medications.	Wis. Stat. 115.365 Suicide prevention programs Wis. Stat. 115.368 Protective behaviors programs
Identifies and monitors students and school personnel who are known to be at high risk for emergency-care needs.	Emergency information is available for each student.	Wis. Stat. 115.80 Identifying and providing special education to children with exceptional educationneeds
	Approved first aid and CPR instruction is offered to school personnel.	
	Medication-administration training is updated, as appropriate, for those designated to administer medications.	Wis. Stat. 118.125 Pupil records Wis. Stats. 146.81-84 Patient health care records
	Emergency-care and medication-administration needs of students and staff are met.	Wis. Stat. 252 Communicable disease
	Crisis needs are met and appropriate referrals made.	Wis. Stat. 49.45(39) School based Medicaid services
	Individual emergency plans for students and personnel with special requirements for emergency care are in place and periodically reviewed.	Wis. Stat. 115.91 Education for school-age parents Local school district policies
Contributes health-related information to accident reports when health issues are present.	Accident reports are reviewed and maintained.	
Assesses and transfers pertinent accident information to the student health record.	Student physical health records document significant injuries.	

ROLE: Planner and Coordinator of Student Health Care: Emergency Nursing Services, Communicable Disease, Health Assessment, and School Safety

Suggested Objectives	Desired Results	Related Standards, Laws, and Policies
Counsels students, parents, and staff on age-specific injury prevention and health promotion (for example, medication usage and poison prevention for elementary school children or seat belt compliance for high school youth).	Students and staff communicate a knowledge of potential age-specific accidents and injury prevention. Students and staff demonstrate problem-solving skills in preventing future accidents and promoting health.	
Maintains emergency-care skills and knowledge.	Appropriate nursing care procedures and practices are implemented. Safety standards are practiced.	
Annually evaluates student and employee accident information and makes recommendations for injury prevention and health promotion.	Health and safety policies and procedures are reviewed and updated annually.	
Communicable Disease		
Implements communicable disease policies and procedures for prevention, exclusion, and re-admission.	Appropriate actions (counseling, referral, monitoring, exclusion, or re-admission) are taken to control communicable diseases in the school environment. Reportable communicable diseases are referred to the local public health department and monitored. Unusual incidence or severity of communicable diseases is reported to the medical advisor, school personnel, parents, and students, as appropriate.	
Educates students, parents, and school personnel about communicable diseases, including federal and state laws and local school district policies.	Written health policies conforming to federal and state laws and reflecting the school district's mission are accessible to students, parents, school personnel, and community members.	

ROLE: Planner and Coordinator of Student Health Care:
Emergency Nursing Services, Communicable Disease, Health Assessment, and School Safety

Suggested Objectives	Desired Results	Related Standards, Laws, and Policies
	Current literature and resources on communicable diseases are provided to students, parents, and personnel.	
	Consultation is provided to teachers as they plan and conduct education on the prevention and control of communicable diseases.	
	Students, parents, and school personnel demonstrate a clear understanding of recognition, prevention, and control of communicable diseases.	
	Students, parents, and school personnel seek medical attention for diagnosis, treatment, and prevention of communicable diseases.	
Implements plan with administration to ensure compliance with school-immunization laws.	The annual *Documenting Immunization Compliance* report is submitted to the local public health department and the state Division of Health.	
Verifies or provides consultation on verification of the immunization status of students in the school building/district.	All students are immunized according to state statutes or have a signed waiver on file.	
Implements plan with administration to ensure compliance with the employee health examination requirement, exposure control plan, and communicable disease procedures.	School employees comply with the school district employee health examination requirement, bloodborne pathogen exposure control plan, and other communicable disease procedures.	
Health Assessment		
Coordinates and conducts child health assessments at specific ages through various screening tools, observations, and interviews.	Students, parents, and teachers are informed regarding schedules for screening programs and results.	

ROLE: Planner and Coordinator of Student Health Care:
Emergency Nursing Services, Communicable Disease, Health Assessment, and School Safety

Suggested Objectives	Desired Results	Related Standards, Laws, and Policies
	Preschoolers and students are screened and assessed for their health status (vision, hearing, speech, growth and development, motor coordination), according to school district policies.	
Collects data about students' environment and relationships through school observations, home visits, and conferences.	Collected data provides information about students' environment and relationships that may impact their educational program.	
Interprets for students, parents, and school personnel the need for regular and special health assessments and interventions.	Students with actual or potential health problems receive professional attention. Significant health information is reported to students, parents, and school personnel.	
Explores resources with students, parents, and school personnel; makes appropriate referrals.	Current list of school and community resources is available to students, parents, and school personnel.	
Reviews health records and informs parents and school personnel, within the parameters of federal and state laws and local school district policies, of conditions that may affect learning.	School personnel make necessary adjustments/modifications for students with health needs.	
Contacts parents about conditions identified through screenings and observations.	Corrective care is obtained as needed. Reports from physicians and other referral agencies are returned to the school nurse.	
Establishes individual health plans with students, parents, teachers, primary-care providers, and other members of the school team.	Health plans are written and implemented. Students accept remediation, modifications, and/or adjustments (such as glasses or hearing aids).	

ROLE: Planner and Coordinator of Student Health Care: Emergency Nursing Services, Communicable Disease, Health Assessment, and School Safety

Suggested Objectives	Desired Results	Related Standards, Laws, and Policies
Conducts health inservices for teachers to ensure more accurate referral of students based on observations of signs and symptoms.	Teachers recognize signs and symptoms of student health needs.	
	Teachers are knowledgeable of criteria for referrals to the school nurse.	
Coordinates a referral system with school and community professionals.	Resources are better utilized and duplication of services are minimized.	
Assists teachers in developing education units to precede screening.	Students relate the educational program to the screening experience.	
	Student health needs are identified and continuity of care is maintained.	
School Safety		
With the school administration, interprets and implements the laws, policies, and procedures for a safe and healthful environment.	Activities contribute to ensuring the provision of a safe and healthful environment for all students.	
	Fire drills, tornado alerts, and civil defense activities are conducted.	
	Parents, students, and school personnel are informed of bus safety and transportation policies.	
	Students use safety equipment (safety glasses, seat belts, or football helmets) appropriately.	
	Playground equipment is safe and in good repair.	
Assists with periodic inspection of the school plant.	Environmental hazards are reported and corrected.	

ROLE: Planner and Coordinator of Student Health Care: Emergency Nursing Services, Communicable Disease, Health Assessment, and School Safety

Suggested Objectives	Desired Results	Related Standards, Laws, and Policies
Informs the administration of unsafe equipment and practices (noted on accident reports or observed) that influence health and academic achievement.	Accident/injury hazards are reduced. A smoke- and AOD-free environment is maintained.	
Counsels appropriate personnel regarding remedial action for infractions of safety and health.	School grounds and buildings comply with state codes.	
Promotes and participates in improving the emotional climate of the school.	The educational and working environment shows evidence of reduced stress. Student altercations are reduced.	
Acts as a resource person for teachers planning curricula related to safety and a healthful environment.	All school staff recognize the need for a safe and healthful school environment and include these concepts as a part of instruction.	
Demonstrates knowledge of the philosophy and/or mission of the school district, the kind and purpose of its curricular and extracurricular activities, and its programs and special services.	School district policy demonstrates integral relationship of school health resources. Overall school health plan and services reflect coordination of school and community resources to address students' primary, secondary, and tertiary care needs.	
Demonstrates knowledge of the roles and responsibilities of school staff and encourages their participation in identifying health, safety, and education needs of students and their families.	School staff participate in school health activities which help identify health needs and trends.	

ROLE: Planner and Coordinator of Student Health Care: Emergency Nursing Services, Communicable Disease, Health Assessment, and School Safety

Suggested Objectives	Desired Results	Related Standards, Laws, and Policies
As necessary, discusses appropriately with parents, teachers, and school personnel the ongoing care and self-care issues of students.	Individual health-care and education plans are implemented. School personnel know the health conditions of students and have the necessary information to make appropriate modifications.	
As necessary, recognizes and uses appropriately the expertise of school staff to meet student health, developmental, and educational needs.	Communication with administrators, student-service providers, and other school staff provides evidence of their understanding of school system linkages and the application of the unique contributions of each discipline in meeting student health, developmental, and educational needs. Students and their families receive appropriate information and the care they need. Guidelines for sharing health information comply with confidentiality statutes.	
Advocates for students and families in multi-disciplinary collaboration.	Conference/meeting reports, student health records, and the daily log document the school nurse's role as an advocate. The school nurse is an integral member of multi-disciplinary teams and committees.	
Collaborates with student-service providers and others to observe and evaluate factors in the home environment and in relationships with family members and others that may affect a student's health and education; functions as school-home liaison in student/family health and education concerns.	Family information relevant to the health and education of the student is recorded and communicated, in accordance with federal and state laws and local school district policies. Nursing interventions are documented and reviewed.	

ROLE: Planner and Coordinator of Student Health Care:
Emergency Nursing Services, Communicable Disease, Health Assessment, and School Safety

Suggested Objectives	Desired Results	Related Standards, Laws, and Policies
Advises administrators and school board members of collaborative plans to meet the health-care needs of students, as necessary.	Health needs and resources are identified.	
Encourages community participation to identify the health-care needs of students and families.	School district policies reflect coordination and participation in community health-care resources. Parents and community members participate in school health and community assessment activities that help identify health-care needs and trends.	
Participates in developing and using community health-care resources to benefit students and families.	Facilities and services are accessible to and used by parents and students. The school nurse serves in a position of leadership on voluntary and governmental bodies and/or advisory boards within community health and social service systems.	
Promotes and participates in the development of collaborative school-community health projects.	Community education programs provide health-related courses. Linkages/interagency agreements are in place which facilitate cohesive intervention with clients.	
Serves as a school liaison for ongoing school and community agency cooperation and collaboration related to health issues.	Guidelines for sharing information comply with confidentiality statutes. Community committees and task forces concerned with child health have appropriate school nursing representation.	

ROLE: Planner and Coordinator of Student Health Care:
Emergency Nursing Services, Communicable Disease, Health Assessment, and School Safety

Suggested Objectives	Desired Results	Related Standards, Laws, and Policies
Identifies community agencies as resources for students and their families as well as school staff; evaluates agencies to determine their appropriateness (eligibility criteria, costs, accessibility, and so forth) for meeting clients' needs.	Students, parents, and school personnel consult the school nurse regarding available health-care resources. Memoranda of Understanding/Agreements exist within and outside the community to ensure continuity of service and care.	
Communicates and provides case management when collaborating with community providers regarding client interventions, as appropriate.	Communication with community health and social service providers offers evidence of understanding system linkages and an appreciation of the unique contributions of each discipline in meeting primary, secondary, and tertiary care needs of students.	

ROLE: Teacher

Suggested Objectives	Desired Results	Related Standards, Laws, and Policies
Uses all health service contacts as learning experiences and as an opportunity to provide safety for students and school staff.	Students demonstrate responsible self-help skills.	ANA Standards of School Nursing Practice, 1983
	Students demonstrate improved health-care consumer skills.	ANA Code for Nurses with Interpretive Statements, 1985
Initiates/participates in the assessment of health education needs for the school community and facilitates group discussions about health concerns.	Students with health concerns demonstrate improved health knowledge and behavior.	NASN Code of Ethics with Interpretive Statements for the School Nurse, 1990
	Students with chronic health conditions have the opportunity to participate in support groups.	NASN School Nursing Practice: Roles and Standards, 1990
		Wis. Stat. 441 Nurse Practice Ac
	Families demonstrate improved health knowledge and behaviors.	Wis. Stat. 115.35 Health problems education
	School personnel and community groups receive health education/information.	Wis. Stat. 118.01 (2)(d) Education goals and expectations
Promotes the formation of and serves on health curriculum committees; participates in designing and developing a health curriculum.	A health curriculum for school-age children, based on sound learning and developmental theories, is designed and implemented.	Wis. Stat. 118.019 Human growth and development instruction
	Health-promotion principles are applied across the school community: healthful environment, student services, student and adult programs, curriculum and instruction, and school-community partnerships.	Wis. Stat. 118.33 High school graduation standards Wis. Stat. 121.02 (j), (k), and (L) Health education
Initiates health education for school personnel.	School personnel demonstrate improved health knowledge and application of health concepts.	Local school district policies

ROLE: Teacher

Suggested Objectives	Desired Results	Related Standards, Laws, and Policies
Provides health teaching, counseling, current literature, and information for students, families, and school personnel, as needed.	Students, parents, and school personnel consult the school nurse for health information, materials, and health-care resources.	
	The school nurse delivers formal health instruction in the classroom in collaboration with teachers.	
	Recommended health materials are purchased.	
Informs students, families, and school personnel of health education resources in the community.	Health education resources in the community (diabetes, lung, heart, and epilepsy organizations; local health departments) are used.	

ROLE: Investigator

Suggested Objectives	Desired Results	Related Standards, Laws, and Policies
Practices under ethical codes for the nursing and teaching professions.	Ethical principles are applied in daily practice.	ANA Standards of School Nursing Practice, 1983
	School nurse demonstrates competence in principles of human relations.	ANA Code for Nurses with Interpretive Statements, 1985
Conducts and/or participates in studies of nursing practice to improve standards.	School nurse demonstrates improved school nurse practice.	NASN Code of Etnics with Interpretive Statements for the School Nurse, 1990
Writes and submits articles to nursing and educational journals.	Articles are published in health and/or educational journals.	NASN School Nursing Practice: Roles and Standards, 1993
	Results of research findings are used to improve school nursing practice, develop institutional policies and procedures, create guidelines for client care, develop programs, and address other institutional issues.	Code of Federal Regulations, Title 45, Section 46 (1986) Wis. Stat. 441 Nurse Practice Act Local school district policies
Identifies areas for research and/or participates in research related to student health; applies responsible standards of research, including a mechanism for the protection of human subjects.	Collaborates with researchers from institutions whose research aims have legitimate health or educational purposes.	

ROLE: Within the Nursing Discipline

Suggested Objectives	Desired Results	Related Standards, Laws, and Policies
Develops a job description.	The school board approves a written job description.	ANA Standards of School Nursing Practice, 1983
Annually develops performance objectives; studies and evaluates job performance.	Performance objectives related to district policies, procedures, and goals are reviewed by the school nurse and administrators.	ANA Code for Nurses with Interpretive Statements, 1985
	Nursing practice objectives are completed and reviewed by the school nurse, peers, and the nursing supervisor.	NASN Code of Ethics with Interpretive Statements for the School Nurse, 1990
Seeks nursing, medical, and educational consultation for direction of professional growth.	Educational plans reflect the expanding role of the school nurse.	NASN School Nursing Practice: Roles and Standards, 1993
Recommends professional literature and materials for school district purchase.	State and local continuing education requirements are met.	Wis. Stat. 441 Nurse Practice Act
	School district provides professional health journals and nursing texts.	Wis. Admin. Code PI 3.51 School nurse certification
Reads and utilizes findings of professional literature.	School nursing and school health resource material is used.	
Participates in mentoring relationships with new school health professionals in need of guidance.	Demonstrates knowledge of current health issues.	
Attends and/or participates in inservice meetings and educational programs within the school district.	Relevant material is applied to the total school health program.	
Pursues continued professional growth and development through educational programs and state and national certification.	New knowledge is integrated into professional practice.	
Maintains membership and participates in state and national professional organizations.	Professional organizations' spheres of influence are broadened.	

School Personnel Roles and Activities

Title and Description	Legal Requirements	Activities Related to School Health Program	Related Nursing Role
Superintendent of Schools A district administrator who is the administrative head of the school district	*Subchapter XII–School Administration* PI 3.55* General Requirements Completion of an approved specialist degree program or the equivalent; completion of an approved master's degree program or equivalent in the area of administration PI 3.56* School District Superintendent 1) Shall hold or be eligible to hold a principal license 2) Identifies 12 specific graduate semester credits necessary to qualify	Provide educational leadership Allocate monetary resources and materials Manage personnel Act as a liaison with the community	Planner and coordinator of school health care Communicator Investigator Role within discipline of nursing
Assistant Superintendent of Schools A district administrator who works in cooperation with the superintendent of schools	The assistant superintendent license no longer exists; assistant superintendents must hold an administrators license	Assume the responsibilities of the superintendent when absent Oversee the day-to-day operations of schools Work closely with administrative personnel	Planner and coordinator of school health care Communicator Investigator Role within discipline of nursing
Principal An administrator of an elementary-, middle-, or secondary-level school	*Subchapter XII–School Administration* PI 3.57* (Elementary and Middle School Level) PI 3.58* (Middle and Secondary School Level) Identifies the 12 specific graduate semester credits necessary	Implement school health program at individual school Allocate services and supplies for that school Supervise administrative activities of health personnel assigned to the school Provide for the safety of students, staff, and physical plant Interact directly with students	Planner and coordinator of school health care Communicator Investigator Role within discipline of nursing

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*Requirements per Wisconsin Department of Public Instruction

Title and Description	Legal Requirements	Activities Related to School Health Program	Related Nursing Role
Classroom Teacher A licensed professional school employee whose work includes the exercise of any educational function for compensation, including instructing students or administrating, directing, or supervising any educational activity	*Subchapter II—General Requirements* PI 3.05* General requirements for licensure PI 3.05(11)* Minimum grade point average of 2.75 on a 4.0 scale or standing in upper 50 percent of the class as determined by policy of the institution PI 3.05(12)* Initial professional education program is a baccalaureate degree in which at least one-third of semester hours are in the area of general education PI 3.05(13)(a)(b)(c)* Specific licensure requirements for early childhood, elementary, middle, secondary, and K-12	Teach school health curriculum Identify health and safety concerns in the classroom and school Identify students with special health-care needs Refer students to appropriate person such as student service providers when health and education concerns arise Implement special health-related programs for specific children Participate in IEP meetings Interact directly with students and parents	Teacher Planner and coordinator of school health care Provider of school health care Communicator Investigator
Special Education Teacher A licensed professional school employee whose work includes the education of students with exceptional education needs because of emotional disturbance, hearing disability, learning disability, cognitive disability, autism, traumatic brain injury, or other developmental disability, physical, or orthopedic disability, speech language disability, or visual disability	*Subchapter VII—Special Education* PI 3.25* Special education applicability and general requirements PI 3.25(2)* Applicant completed an approved program, meets general requirements in PI 3.05 and requirements for the general area of specialization in PI 3.26 to 3.29 PI 3.25(3)(b)* General preparation in special education—requires at least 14 semester credits in 6 areas of general special education	Teach health curriculum to special education children according to developmental level Identify specific safety concerns in the classroom and school Participate in IEP meetings Collaborate with school health-care personnel to provide health care May carry out uncomplicated medical procedures such as medication administration, as delegated by the physician, school nurse, or principal Interact directly with students and parents	Teacher Planner and coordinator of school health care Provider of school health care Communicator Investigator

Title and Description	Legal Requirements	Activities Related to School Health Program	Related Nursing Role
Speech and Language Pathologist A licensed professional who provides direct intervention services to students with speech/language disabilities, which will result in the acquisition or improvement of speech and language skills needed for effective communication exchange and interaction with others	*PI 3.35* Speech and Language Pathologist–820 PK-12* PI 3.35*(1) meets general requirements in PI 3.05 PI 3.35*(2) has earned a master's degree in communication disorders including speech pathology, auditory, and language disorders; has a minimum of 60 semester credits of which at least 20 semester credits are graduate credits selected in accordance with specific areas indicated in PI 3.35(2)(a)(b)(c)(d)(e)	Administer screening and diagnostic tests to students with speech and language problems Provide individual or group speech therapy for children with speech/language problems Assess individual student's needs for services Collaborate with teachers, student service providers, family, and others, as needed Participate in IEP meetings Interact directly with students	Planner and coordinator of school health care Provider of school health care Communicator
School Audiologist A licensed professional who teams with other school professionals to optimize the auditory-verbal communication skills and auditory learning of students with hearing disabilities by (1) ensuring the prompt identification and evaluation of children with hearing disabilities and (2) providing the auditory management services necessary to ensure optimal use of residual hearing	*PI 3.355* School Audiologist–822 PK-12* PI 3.55*(a) at least 12 semester credit hours in professional education meeting the requirements in s. PI 3.05(1), (2m), (8), (9), and (10) plus course work in three specified areas and at least 50 hours of supervised practicum PI 3.555*(b) will have a master's degree in audiology from an institution accredited by the educational standards board of the American Speech-Language-Hearing Association	Coordinate and provide technical assistance to school district hearing screening programs. In some school districts, school audiologists may screen difficult-to-test children Encourage medical evaluations of children failing hearing screening tests Provide or facilitate educationally relevant hearing evaluations Participate in IEP meetings Provide direct auditory management services including auditory training, provision of assistive hearing technology, and communication management training to other school staff	Planner and coordinator of school health care Provider of school health care Communicator

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Title and Description	Legal Requirements	Activities Related to School Health Program	Related Nursing Role
School Occupational Therapist A licensed professional who provides services to persons with disabilities to maximize their independent function in activities of daily living, work, and play; prevent disabilities from increasing; and promote health and production in purposeful activity	*PI 3.37* School Occupational Therapist–812 PK-12* A person who is certified as an occupational therapist by the department of regulation and licensing, medical examining board	Participate in IEP meetings to evaluate student's need for services Participate in developing IEPs Develop, implement, and supervise treatment plans Collaborate with teachers, student service providers, primary physician and student/family regularly Interact directly with students	Planner and coordinator of school health care Provider of school health care Communicator Investigator
School Occupational Therapy Assistant A licensed professional who provides occupational therapy under the supervision of a licensed school occupational therapist	*PI 3.365* School Occupational Therapy Assistant–885 PK-12* A person who is certified as an occupational therapy assistant by the department of regulation and licensing, medical examining board	Under supervision of the occupational therapist, assist in implementing a treatment plan Interact directly with students Collaborate with teachers, student service providers, students, family, and others as necessary	Provider of school health care Communicator
School Physical Therapist A licensed professional who provides services to students to prevent or minimize disability, develop and improve sensory and motor function, control postural deviations, and establish and maintain motor performance within the child's capabilities	*PI 3.337* School Physical Therapist–817 K-12* A person who is licensed as a physical therapist by the department of regulation and licensing, medical examining board	Evaluate student's need for services Develop, implement, and supervise treatment plans Collaborate with teachers, student service providers, physical therapy assistants, students, and family Participate in IEP meetings	Planner and coordinator of school health care Provider of school health care Communicator Investigator

Title and Description	Legal Requirements	Activities Related to School Health Program	Related Nursing Role
School Physical Therapist Assistant An individual who under the supervision of a physical therapist provides physical therapy to students	*PI 3.375* School Physical Therapist Assistant–886 PK-12* A person who has graduated from a physical therapist assistant associate degree program accredited by the American Physical Therapy Association	Under supervision of a physical therapist, assist in implementing a treatment plan Communicate with teachers, student service providers, students, and family in collaboration with the physical therapist	Provider of school health care Communicator
Special Education Program Aide A licensed individual who under the supervision of a teacher provides education-related services to students	*PI 3.39* Special Education Program Aide–883* A person who is at least 18 years of age and meets one of the following requirements: 1) has at least three years of experience in supervision of structured youth activities 2) has completed at least three years of college education 3) has a combination of education and experience under subs (1) and (2) totaling three years 4) has completed a two-year program in child care and development approved by the DPI	Under the supervision of professional school health personnel, assist with students' physical needs in the classroom Under the direction of the school nurse, perform basic medical and nursing services Communicate with teachers, student service providers, and family in collaboration with the school nurse regarding health-related issues	Provider of school health care Communicator
School Counselor A licensed professional who assists students to acquire developmentally appropriate skills in the following areas: educational, personal, and social health; career development by providing guidance and counseling individually, in small groups, or in large classes	*Subchapter XI–Pupil Services* *PI 3.49* School Counselor–966* PI 3.49*(2)(a) Master's degree with a major in school counseling and guidance, or a master's degree with at least 30 semester credits in an approved school counseling and guidance program, and institutional endorsement PI 3.49*(2)(b) Eligibility for a license to teach, general requirements in PI 3.05 PI 3.49*(2)(c) Demonstrated proficiency in each of 11 clearly stated areas	Provide individual assessment of student needs Refer students to school and community health-care providers, as needed Act as liaison with parents, teachers, and health-care professionals in educational planning Provide student and family counseling concerning education problems arising out of child's health or handicapping condition Participate in IEP meetings, as appropriate Interact directly with students	Communicator Provider of school health care Teacher Investigator

Title and Description	Legal Requirements	Activities Related to School Health Program	Related Nursing Role
School Social Worker A licensed professional who uses training in mental health, systems, individual, and family dynamics to provide prevention and intervention services to students and families. The school social worker is a liaison among school, community and family in activities that enhance the student's ability to succeed academically and socially	*PI 3.54* School Social Worker–50* Has obtained institutional endorsement and has completed or possesses all of the following: 1) a master's degree in social work 2) competencies in nine clearly stated areas 3) at least 18 semester credits of professional education or its equivalent; at least six of these semester credits shall be in professional education 4) at least two years of social work experience dealing with children and youth; one of these years shall be with elementary-, middle-, or secondary-level students in a school or institution whose major responsibility is to serve children and youth	Evaluate student needs for services Act as an outreach worker for students and families Act as an advocate for students and their families Collaborate with school personnel, student service providers, student, family, and community agencies to coordinate services Provide individual and group counseling in schools Counsel students and families directly Participate in IEP meetings Initiate or participate in developing collaborative services between schools and community agencies	Planner and coordinator of school health care Communicator Provider of school health care Teacher Investigator
School Psychologist A licensed professional trained in both the mental health and educational system to provide services to students with and without disabilities. The school psychologist provides services in the areas of psychoeducational assessment, interventions, and case management of special education due-process procedures	*PI 3.52* School Psychology–62* 1) Meets all requirements for the provisional school psychologist license under PI 3.52 and possesses: a. a master's degree from an accredited college or university plus 30 additional graduate credits for DPI licensure b. coursework with a minimum of 48 graduate-level semester credits in seven clearly defined areas c. education foundations including at least nine semester credits in three clearly defined areas; at least six of the semester credits shall be at the graduate level d. core professional program including at least 33 graduate semester credits in five clearly defined areas	Provide psychological educational screening, assessment, diagnosis, and intervention for students Assist in developing individual education plans (IEPs) Provide individual and group counseling for students Consult with teachers, school personnel, student service providers, student and family, and community agencies Interact directly with students Participate in IEP meetings	Planner and coordinator of school health care Communicator Provider of school health care Teacher Investigator

continued next page

Title and Description	Legal Requirements	Activities Related to School Health Program	Related Nursing Role
School Psychologist (cont.)	2) graduate from an approved program for preparation of school psychology resulting in a Doctor of Philosophy, Doctor of Education, or Education Specialist degree or consisting of at least 60 graduate semester credits 3) completion of one of the following: a. one year of successful experience as a school psychologist under the supervision of a cooperating school psychologist and a written recommendation from the school system administration b. a 12-credit graduate semester internship in school psychology		
Medical Advisor A licensed physician who provides consultation to school district administration and school nurses related to school health services program.	Physician licensed in the State of Wisconsin	Act as a school health consultant to school district administration and the school nurse Act as liaison to the medical community Assist in the development, maintenance, and evaluation of school health policy	Planner and coordinator of student health care Communicator Investigator

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Title and Description	Legal Requirements	Activities Related to School Health Program	Related Nursing Role
Athletic Trainer A certified professional trained in athletic health care who provides services which include the prevention, recognition, and rehabilitation of injuries caused during physical activity or athletics	** National Athletic Trainers' Association Board of Certification 1) A bachelor's degree in athletic training, health, physical education, or exercise science 2) Coursework in human anatomy, human physiology, biomechanics, exercise physiology, athletic training, nutrition psychology, and counseling 3) Successful completion of written, practical, and oral examinations	Collaborate with school personnel to prevent athletic injuries Identify, evaluate, and provide care for students with athletic injuries Rehabilitate and recondition student athletes	Provider of student health care Communicator Planner and coordinator of student health care
School Health Paraprofessional An individual who under the supervision of a registered nurse provides nursing services	***School Health Paraprofessional training course through a vocational technical college or other recognized nurse aide training program, successfully completed prior to or within one year of employment	Under the direction of the school nurse: — provide basic first aid care — assist with monitoring, reporting, and documenting — assist with school health screenings — help maintain immunization and other student health records — help maintain the school health office — administer medications and carry out nursing procedures — facilitate communication among parents, students, school personnel, and the school nurse — maintain confidentiality	Provider of student health care Communicator

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** National Athletic Trainers' Association, 2952 Stemmons Freeway, Dallas, TX 75247; (214) 637-6282/2208 (fax)

*** Department of Health and Family Services, Bureau of Quality Assurance, Nurse Aide Training and Registry Unit, 1 W. Wilson, Madison, WI 53707; (608) 267-3565

Nurse's Code of Conduct

Preamble

Acknowledging the diversity of the laws and conditions under which school nurses practice, NASN believes in a commonality of moral and ethical conduct.

1. **Client Care**

   The school nurse is an advocate for students, families, and members of the school community. The school nurse provides health services, and works to support the client's active participation in health decisions. Each individual's inherent right to be treated with dignity and confidentiality is respected. All clients are treated equally regardless of race, gender, socio-economic status, culture, age, sexual orientation, disability, or religion.

Interpretive Statements

A. School nurses uphold a moral obligation to recognize human existence as the only prerequisite for all persons to be worthy of dignity, respect, and justice.

B. School nursing services support and promote individuals' and families' ability to achieve the highest quality of life as understood by each individual and family.

C. School nursing services are delivered with nonprejudicial behavior; clients' value systems are respected at all times.

D. School nurses safeguard clients' rights to determine their own health-care decisions with the use of accurate and complete information. School nurses safeguard their clients' right to privacy through confidentiality.

2. **Professional Competency**

   The school nurse maintains the highest level of competency by enhancing professional knowledge and skills and by collaborating with peers, other health professionals, and community agencies, adhering to the Standards of School Nursing Practice.

Interpretive Statements

A. The profession of nursing is obligated to provide competent nursing care. The school nurse must be aware of the need for continued professional learning and must assume personal responsibility for currency of knowledge and skills.

B. It is necessary for school nurses to have knowledge relevant to the current scope of practice. Since individual competencies vary, nurses consult with peers and other health professionals with expertise and recognized competencies in various fields of practice. When in the client's best interest, the school nurse refers to other health professionals and community health agencies.

C. Nurses are accountable for judgments made and actions taken in the course of nursing practice. *School Nursing Practice: Roles and Standards* reflects a practice grounded in ethical commitment. The school nurse is responsible for establishing a practice based on these standards.

3. **Professional Responsibilities**

   The school nurse participates in the profession's efforts to advance the standards of practice, expand the body of knowledge through nursing research, and improve conditions of employment.

Interpretive Statements

A. The school nurse is obligated to demonstrate adherence to the profession's standards by monitoring these standards in daily practice and participating in the profession's efforts to improve school health services.

B. The school nurse recognizes, participates in, and promotes research as a means to advance school health services and adheres to the ethics that govern research as follows:
   1) Right to privacy and confidentiality
   2) Voluntary and informed consent
   3) Awareness of and participation in the mechanisms available to address violation of the rights of human subjects.

Reprinted with permission from "Code of Ethics with Interpretive Statements for the School Nurse," National Association of School Nurses (rev. 1996).

Code for Nurses

1. The nurse provides services with respect for human dignity and the uniqueness of the client, unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems. The nurse safeguards the client's right to privacy by judiciously protecting information of a confidential nature.
2. The nurse acts to safeguard the client and the public when health care and safety are affected by the incompetent, unethical, or illegal practice of any person.
3. The nurse assumes responsibility and accountability for individual nursing judgments and actions.
4. The nurse maintains competence in nursing.
5. The nurse exercises informed judgment and uses individual competence and qualifications as criteria in seeking consultation, accepting responsibilities, and delegating nursing activities to others.
6. The nurse participates in activities that contribute to the ongoing development of the profession's body of knowledge.
7. The nurse participates in the profession's efforts to implement and improve standards of nursing.
8. The nurse participates in the profession's efforts to establish and maintain conditions of employment conducive to high quality nursing care.
9. The nurse participates in the profession's effort to protect the public from misinformation and misrepresentation and to maintain the integrity of nursing.
10. The nurse collaborates with members of the health professions and other citizens in promoting community and national efforts to meet the health needs of the public.

Reprinted with permission from "Code for Nurses with Interpretive Statements," American Nurses Association (1985).

Documentation of Delegation of Nursing Procedures

Student Name

Student No.

Instruction: This form should be completed and maintained in the school health office file whenever delegation of nursing tasks by the school nurse to other school personnel occurs. Delegation includes instruction and supervision of nursing procedures.

The undersigned school personnel have been instructed in the procedure(s) as indicated below. The initials of the nurse indicate satisfactory return demonstration of the ability to carry out the identified nursing task(s). Both the registered nurse and the school personnel agree that the task(s) can be safely delegated and carried out by this person with periodic supervision at the discretion of the school nurse.

Trainees' Names				
Nursing Procedure	Date Trained	Date Trained	Date Trained	Date Trained
Blood Glucose Monitoring				
Insulin Administration				
EpiPen/AnaKit				
Nebulized Medication				
GT Feeding				
Humidify Trach				
Monitor Oxygen				
Suction Oral/Trach				
Urinary Catheterization				
Ostomy Care				
Other				

Signature of School Nurse Providing Instruction/Initials

Signature of School Nurse Providing Instruction

July 94 101390

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State and Federal Laws Related to School Nursing

Direct or Paraphrase Titles for Statutes Related to School Health Services*

48	Children's Code
48.981	Abused or neglected children
101.055	Public employee safety and health (clean indoor air)
101.58	Right-to-know
115.01(11M)	School nurse (definition)
115.34	School lunch
115.341	School breakfast
115.343	Morning milk program.
115.347	Direct certification of eligibility for school nutrition programs
115.35	Health problems education
115.362	Youth alcohol and other drug abuse programs
115.365	Assistance to schools for suicide prevention programs
115.368	Assistance to schools for protective behaviors programs
115.40	Grants for collaborative service programs
115.76-89	Subchapter V: Children with exceptional educational needs
115.91-93	Subchapter VI: Education for school-age parents
118.01	Educational goals and expectations
118.019	Human growth and development instruction
118.07	Safety requirements
118.12(16)	School board duties immunization plan
118.126	Privileged communications
118.13	Pupil discrimination prohibited
118.15	Compulsory school attendance
118.153	Children at risk
118.17	Indigent children
118.125	Pupil records
118.24(2)(f)	Establish procedures for referral of students with problems related to alcohol and other drugs
118.25	Health examinations (requirements for public school employees)
118.255	Health treatment services for children with special physical or mental health treatment needs
118.29	Administration of drugs to pupils and emergency care
118.33	High school graduation standards
120.13(1)	School government rules; suspension; expulsion
120.13(11) (a) and (b)	Nurses and dentists (regulations for employment in schools by county population)
121.02(1)	School district standards
	(a) (professional school staff shall be certified or licensed by the department)
	(b) professional staff development plan
	(e) provision for guidance and counseling services
	(g) provision shall be made for emergency nursing services
	(i) provision for safe and healthful facilities
	(j) health and physical education instruction in elementary and high schools
	(k) written, sequential curriculum plan with objectives and course content

	(l) regular instruction in health, physical education, etc
	(p) compliance with high school graduation standards
	(q) evaluate the performance of certified school personnel
146.81-84	Patient health care records
250.06	Public health nurses
251	Required services of local health departments
252.04	School entrance immunization requirements
252.14-15	AIDS
252.21	Communicable diseases; schools; duties of teachers, parents, officers
441	Board of Nursing (Nurse Practice Act)
448	Medical practices (Medical Practice Act)
450.09	Pharmacy practice
895.48	Civil liability exception; emergency care ("Good Samaritan" law)
905.04	Physician-patient, registered nurse-patient, chiropractor-patient, psychologist-patient, social worker-patient, marriage and family
940	Crimes against life and bodily security
948	Crimes against children

*Paraphrase titles are in parentheses.

Wisconsin Administrative Codes

ILHR 32.50	Bloodborne Pathogens Standard

HSS 90	Birth to Three Program
HSS 139	Qualifications of public health professionals employed by local public health agencies
HSS 144	Immunization of students
HSS 145	Communicable diseases

PI 3.51	School nurse certification
PI 4.71	Pupil services programs: common rules
PI 4.73	School nursing programs: specific rules
PI 8.01	School district standards
PI 9	Nondiscrimination
PI 11	Rules implementing Subchapter V of Chapter 115, Children with exceptional educational needs
PI 19	School age parents
PI 32.03	General alcohol and drug abuse

N6	Standards of practice for Registered Nurses and Licensed Practical Nurses
N7	Board of Nursing rules of conduct

Federal Regulations

20 USC 1401-80	Individuals with Disabilities Education Act (IDEA)
29 USC 794	Section 504 of the Vocational Rehabilitation Act of 1973
29 CFR	1910.1030 Bloodborne Pathogen Standards
42 USC, 12112 340-96	Americans With Disabilities Act of 1990 (ADA)
42 USC, 1758 1910.1030	Federal School Nutrition Program
20 USC 1232g 34 CFR 99	Family Educational Rights and Privacy Act (FERPA)
34 CFR 76.730-34	General Education Provision Act

Appendix I

Sample Letters to Parents about Head Lice and Conjunctivitis

Sample Letter to Parents about Head Lice

Dear parent or guardian:

☐ A student in our school has head lice.

☐ Your child has head lice.

Please do not be alarmed, as this is a common occurrence in schools. Head lice are not a sign of unclean people or homes.

Please take these precautions

1. Check your child's hair for lice eggs (also called nits).
2. If you suspect your child has head lice, ask your health-care provider to diagnose the problem and recommend appropriate treatment.
3. Tell us if your child is diagnosed as having head lice.
4. If head lice are diagnosed, do not return your child to school until she or he has been treated.

Information about Head Lice

What are they? Head lice are tiny insects that live only on people's scalp and hair. They hatch from small eggs (nits) that are firmly attached to the individual hairs near the scalp and cannot be easily moved up or down the hair (as can specks of dandruff). They look like grains of sand. Nits may be found throughout the hair but are most often located at the back of the scalp, behind the ears, and at the top of the head. The eggs hatch in about 10 days, with new lice reaching adulthood in about two weeks. The female louse, about the size of a sesame seed, can live for 20 to 30 days and can lay about six eggs a day. The lice live by biting and sucking blood from the scalp. Lice can survive up to 8 hours between feedings and can do so off the body. Until a person with head lice is treated, they can transmit them to others.

How should you check for head lice? You probably will not see the lice, only the eggs. These are tiny, pearl-gray, oval-shaped specks attached to the hair near the scalp. Look carefully, using a magnifying glass and natural light. Search for nits at the back of the neck, behind the ears, and at the top of the head.

How does a person get head lice? Anyone who has close contact with an infested person or shares personal items can become infested. Lice are spread only by crawling from person to person directly or onto shared personal items, such as combs, brushes, head coverings, clothing, bedding, or towels.

What should you do about head lice? If your child does have head lice, your health-care provider may want to treat everyone in your family. Everyone should be checked, and anyone with nits should definitely be treated.

To Get Rid of Head Lice

1. **Use a medicine that your health-care provider prescribes or recommends.** Use any of these products very carefully, and consult a physician before treating infants, pregnant or nursing women, or people with extensive cuts or scratches on the head or neck.

2. After appropriate treatment, removal of nits is not necessary to prevent spread, although some times removal is done for aesthetic reasons. Removal is a difficult and time-consuming process because nits have such a firm grip on the hair. A solution of vinegar and water may help loosen nits so you can remove them with a special fine-toothed nit-removal comb.

3. **Check for nits daily for the next 10-14 days.** Then repeat the treatment to kill any newly hatched lice.

4. **Clean personal items and surroundings**
   - Machine wash all washable and possibly infested items in **HOT** water. Dry them in a **HOT** dryer.
   - Put nonwashable items (furry toys or pillows) in a **HOT** dryer for 20 minutes or dry clean them.
   - Seal items that cannot be washed or dried in a plastic bag for 10 days (any eggs or lice present will die in this time).
   - Soak combs and brushes for 10 minutes, or wash them with a shampoo approved to kill lice.
   - Thoroughly vacuum rugs, upholstered furniture, and mattresses.
   - Do not use insecticide sprays because they can be harmful to people and animals.

When can your child return? Your child may come back as soon as the shampoo has been used, you have removed as many nits as possible from your child's hair, and you have cleaned or stored personal items. Remember that you must keep checking your child's hair for new nits for at least two weeks.

(Insert your school's policy on return if different from the above statement.)

Sample Letter to Parents about Conjunctivitis

Dear parent or guardian:

☐ A student in our school has conjunctivitis (also called pinkeye).

☐ Your child may have conjunctivitis.

Please take these precautions

1. Watch your child and family members for signs of pinkeye.
2. See your health-care provider if your child develops pinkeye. Your child may need to be given an eye medication.
3. Do not send your child to school until **the day after** you start giving the medicine. If your health-care provider decides not to prescribe an eye medicine, ask for a note to ensure your child's attendance.
4. Tell us if your child is being treated for pinkeye.

Information about Conjunctivitis

What is it? Pinkeye is an infection of the eyes. It is most often caused by a virus but can also be caused by bacteria. The white parts of the eyes become pink or red; the eyes may hurt or feel itchy or scratchy and may produce lots of tears and discharge. In the morning, the discharge (pus) may make the eyelids sticks together. (Note: Some children and adults have allergies that can cause everything listed here *except pus.*) Conjunctivitis is a mild illness and is not dangerous. Doctors may prescribe an antibiotic eye medication if the infection is thought to be due to bacteria.

How do you catch conjunctivitis? The pus is infectious. If children rub their eyes, they get it on their hands. They can then touch someone else's eyes or hands or an object. If other children get discharge on their hands and then touch their own eyes, they can catch it. It can spread easily among young children, who touch their eyes and everything else and who do not know how (or forget) to wash their hands.

What should you do if your child has conjunctivitis?

1. Keep your child's eyes wiped free of discharge. Use paper tissues, and throw them away promptly.
2. **Thoroughly wash your hands after wiping your child's eyes.**
3. Teach your children to wash their hands after wiping their eyes.
4. Ask your health-care provider if your child needs to receive eye medication.
5. Be sure to wash anything that touches your child's eyes (such as washcloths, towels, sunglasses, binoculars, toys, and cameras).

Parent/Guardian Medication or Procedure Consent Form

Full Name of Child

School	Date of Birth
Name of physician ordering medication or procedure	Phone number of physician

Address of physician ordering medication or procedure *Street, City, State, ZIP*

Name of medication or dosage or procedure	Reason for medication or procedure
Hour it is to be given	How it is to be given

I hereby give my permission to the nurse or delegate(s) to give the medication or perform the procedure to my child according to the written instructions of the doctor as shown on the Physician Order Form. I also hereby agree to give my permission to the school nurse to contact the child's physician.

I further agree to hold the Madison Metropolitan School District, and the MMSD employee(s) who is (are) administering the medication or performing the procedure harmless in any or all claims arising from the administration of this medication or the performance of this procedure at school.

I agree to notify the school at the termination of this request or when any change in the above orders is necessary.

Signature of Parent/Legal Guardian	Date Signed

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Sample Medication Administration Authorization Form

Dear

(School Nurse)

Please administer the following medication(s) to

Name of student	School

Diagnosis

Physician Medication Orders

Daily Medications Medicine	Route	Dose	Frequency	Duration	Direct contact shall be made with me should the student receiving the medication develop any of the following conditions or reactions to the medication (if none, so state)
				From: To:	
				From: To:	
				From: To:	

PRN Medications Medicine	Route	Dose	Frequency	Duration	Condition under which medication should be given	Direct contact shall be made with me should the student receiving the medication develop any of the following conditions or reactions to the medication (if none, so state)
				From: To:		
				From: To:		
				From: To:		

Hospital/Clinic/Office	Phone Number

Address *Street, City, State, ZIP*

Physician's Signature	Date

Return this form to

Rev. 3/93 101220

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Medication Incident Report Form

A medication error is defined as failure to administer the prescribed medication within the appropriate time frame, in the correct dosage, in accordance with accepted practice, to the correct student.

Date of Report	School	Prepared by	
Name of Student	Telephone *Area / No.*	Grade	Gender ☐ Male ☐ Female

Home Address *Street, City, State, ZIP*

Date Error Occurred *Mo. / Day / Yr*	Time Noted ☐ am ☐ pm	Person Administering Medication
Name of Licensed Prescriber	Reason Medication Was Prescribed	
Date of Order	Instructions for Administration	

Medication	Dose	Route	Scheduled Time

Describe the error and how it occurred *Use reverse side if necessary*

Action Taken

Licensed Prescriber Notified ☐ Yes ☐ No	Date Notified *Mo. / Day / Yr*	Time Notified ☐ am ☐ pm
Parent/Guardian Notified ☐ Yes ☐ No	Date Notified *Mo. / Day / Yr*	Time Notified ☐ am ☐ pm

Other Persons Notified

Describe the Outcome

Name (Print)	Title
Signature	Date Signed

mederror 10-96

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Documentation of Medication Administration Training and Monitoring

Date

Trainer/Monitor Name and Title

Name of School

Principal's Name

School Personnel Designated to Administer Medications

Medication Administration Procedure	**Satisfactory**	**Unsatisfactory**	**N/A**
Demonstrate proper storage of medication			
Locate and follow medication order			
Identify the student by name			
Demonstrate clean technique for dispensing oral medications			
Demonstrate correct recording of medication given			
Demonstrate correct response in the event of a medication error			
Demonstrate correct action to take in event of unusual circumstances			
Describe resources to be used in an emergeny or when problems arise			

If performance of any of the above activities is unsatisfactory, note re-instruction given

Signature of Trainer/Monitor

Date of Monitoring

Signature of Designated School Personnel

January 1997
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Student Medication Administration Log and Procedures

Student Name	Student Number	Grade

Why medication is given at school

Medication	Dosage	Time to be given

MD/Phone	What to do when supply is low

Date	Time	Init.	Date	Time	Init.	Date	Time	Init.	Date	Time	Init.

Codes

—	Weekend
A:	Absent
D:	Early Dismissal
E:	Medication Bottle Empty
F:	Field Trip
H:	Holiday
N:	No School
O:	No Show (Not Absent)
W:	Dose Withheld
X:	Discontinued

Initial ________ Name ________________

Initial ________ Name ________________

Initial ________ Name ________________

Initial ________ Name ________________

Initial ________ Name ________________

Please return this form to ________________

Rev. 3/93 101220

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Administration of Medication to Students

I. Management of the Medication Administration Program

A. Medication should be administered to students by their parents/guardians at home whenever possible. In all instances where medication is to be administered in the school setting, the physician prescribing the medication has the power to direct, supervise, decide, inspect and oversee the administering of medication.

B. The school nurse shall be the supervisor of the medication administration program in the school.

C. The superintendent or school principal has the authority to authorize in writing that an employee administer oral medication.

D. Medication orders/parental consent:

1. The principal/school nurse shall ensure that there is a proper medication order from a licensed prescriber, including the beginning of each academic year. A telephone order for any change in medication shall be received only by the school nurse.

    a. In accordance with standard medical practice, a medication order form from a licensed prescriber shall contain:
        1) student name;
        2) name and signature of the licensed prescriber, and business/emergency telephone numbers;
        3) name of the medication;
        4) route, dosage, frequency and time of medication administration;
        5) date of the order;
        6) diagnosis;
        7) specific directions for administration.

    b. Additional information shall be obtained from the licensed prescriber, if appropriate:
        1) any special side effects, contraindications and adverse reactions to be observed;
        2) any other medications being taken by the student.

    c. Special medication situations:

        1) for nonprescription medications, i.e., over-the-counter medications, the school nurse shall obtain parental authorization and follow a standing order, which is cooperatively developed with the medical advisor, regarding the administration of nonprescription medications in the school;
        2) designated employees, other than licensed health care providers, may administer oral nonprescription medications with proper written parental authorization.

2. The principal/school nurse shall ensure that there is a written authorization by the parent or guardian which contains:

    a. The parent or guardian's printed name and signature;
    b. approval to have the school nurse or employee designated by the superintendent, principal or school nurse administer the medication in the dosage recommended, and to contact the student's physician directly if the parent/guardian cannot be reached;
    c. person(s) to be notified in the case of a medication emergency.

E. Medication Administration Plan:

1. The principal/school nurse, in collaboration with the parent/guardian whenever possible, shall establish a medication administration plan for each student receiving a medication. Whenever possible, a student who understands the issues of medication administration

shall be involved in the decision-making process and his/her preferences respected to the extent possible. If appropriate, the medication administration plan shall be referenced in other health or educational plans developed pursuant to the Wisconsin Exceptional Education Law, or federal laws, such as the Individuals with Disabilities Education Act or Section 504 of the Rehabilitation Act of 1973.

2. Prior to the initial administration of the medication, the principal/school nurse, when available, shall develop a medication administration plan using the medication consent form which includes:
   a. the name of the student;
   b. a signed order from a licensed prescriber, including business and emergency telephone numbers;
   c. the signed authorization of the parent/guardian, including home and business telephone numbers;
   d. any known allergies to food or medication;
   e the diagnosis, unless a violation of confidentiality or the parent/guardian or student requests that it be documented;
   f. the name of the medication;
   g. the dosage of medication;
   h. any specific directions for administration;
   i. possible side effects, adverse reactions or contraindications;
   j. the duration of the prescription;
   k. the designation of school personnel who will administer the medication to the student;
   l. parental permission to notify other persons, including teachers, of medication administration and possible adverse effects of the medication;
   m. a list of other medications being taken by the student, if not a violation of confidentiality or contrary to the request of the parent/guardian or student that such medication not be documented;
   n. provision of medication administration in the case of field trips and other short-term special school events. Effort shall be made to obtain an employee trained in medication administration to accompany the student. When this is not possible the principal may designate or school nurse delegate medication administration to another responsible adult.

F. The principal/school nurse shall communicate significant observations relating to medication effectiveness and adverse reactions or other harmful effects to the child's parent/guardian and/or licensed prescriber.

G. In accordance with standards of nursing practice, the school nurse may refuse to administer or allow to be administered any medication, which, based on her/his assessment and professional judgement, has the potential to be harmful, dangerous or inappropriate. In these cases, the parent/guardian and licensed prescriber shall be notified by the school nurse and the reason for refusal explained.

H. The school nurse shall have a current pharmaceutical reference available for her/his use, such as the *Physician's Desk Reference* (PDR) or *Nurse's Drug Handbook*.

I. Designated school employees authorized to administer medication to students shall be provided annual instruction on proper procedures for administering medication.

J. Administration of medications by means other than ingestion:

1. School personnel are not required to administer medications by means other than ingestion.
2. Personnel designated to administer medications may indicate a willingness to provide medications, in an emergency or special situation, by means other than ingestion. This is done only under the direction and delegation of the school nurse or licensed physician.

II. Self Administration of Medications

A. Self administration means that a student is able to consume or apply medication in a manner directed by the licensed prescriber, without additional assistance or direction. A student may be responsible for taking his/her own medication after the school nurse has determined that the following requirements are met:

1. The licensed prescriber, parent/guardian and student, where appropriate, provide a written statement which specifies the conditions under which medication may be self administered;
2. The student's health status and abilities have been evaluated by the school nurse who then deems self administration safe and appropriate. As necessary, the school nurse shall observe initial self administration of the medication;
3. The school nurse is reasonably assured that the student is able to identify the appropriate medication, knows the frequency and time of day for which the medication is ordered;
4. The student follows a procedure for documentation of self administration;
5. The school nurse, as necessary, consults with teachers, the student and parent/guardian, if appropriate, to determine a safe place for storing the medication, while providing for accessibility if the student's health needs require it. This information shall be included on the medication administration consent form;
6. The student's self administration is monitored based on his/her abilities and health status. Monitoring may include teaching the student the corrrect way of taking the medication, reminding the student to take the medication, visual observation to ensure compliance, recording the medication was taken, and notifying the parent/guardian or licensed prescriber of any side effects, variation from the plan, or the student's refusal or failure to take the medication.

III. Handling, Storage, and Disposal of Medication

A. All medications to be administered by school personnel or to be taken by self medicating students may be delivered by a student, unless extenuating circumstances necessitate delivery by a parent/guardian or parent/guardian-designated responsible adult, to the school nurse or school personnel designated to administer medication.

B. All medications shall be stored in their original pharmacy or manufacturer labelled containers and in such manner as to render them safe and effective. Expiration dates shall be checked.

C. All medications to be administered by school personnel shall be kept in a securely locked cabinet used exclusively for medications. Medications requiring refrigeration shall be stored in a refrigerator in a secure, locked room.

D. Access to stored medications shall be limited to persons authorized to administer medications. Access to keys and knowledge of the location of keys shall be restricted to the extent reasonably possible.

E. Where possible, all unused, discontinued or outdated medications shall be returned to the student or parent/guardian and return appropriately documented. In extenuating circumstances, with parental consent when possible, such medications may be destroyed by the school nurse. All medications should be returned at the end of the school year.

IV. Documentation and Recordkeeping

A. Each school where medications are administered by the school nurse and/or designated school personnel, a medication administration record shall be maintained for each student who receives medication during school hours.

1. Such record at a minimum shall include a daily log and a medication administration consent form, including the medication order and parent/guardian authorization.
2. The daily log shall contain:

   a. the dose or amount of medication administered;
   b. the date and time of administration or omission of administration, including the reason for omission;
   c. The full signature of the school nurse or designated school personnel administering the medication. If the medication is given more than once by the same person, she/he may initial the record, subsequent to signing a full signature.

3. The school nurse and any designated school personnel shall document in the medication administration record significant observations, as appropriate, and any adverse reactions or other harmful effects, as well as any action taken.
4. All documentation shall be recorded in ink and shall not be altered.
5. Completed medication administration records and records pertinent to self administration shall be filed in the student's pupil physical health record.

B. Reporting and documentation of medication errors.

1. A medication error includes any failure to administer medication as prescribed for a particular student, including failure to administer the medication.

   a. within appropriate time frames;
   b. in the correct dosage;
   c. in accordance with accepted practice;
   d. to the correct student.

2. In the event of a medication error, the school nurse or school personnel designated to administer medication shall notify the parent/guardian immediately. If there is a question of potential harm to the student, the student's licensed prescriber shall also be notified.
3. Medication errors shall be documented by the school nurse and school personnel designated to administer medications on a medication error report form. These reports shall be retained in the school office.
4. The school nurse shall review reports of medication errors and provide consultation to ensure appropriate medication administration in the future.

V. Dissemination of Information to Parents/Guardians Regarding Administration of Medication

Medication policies, procedures, and forms shall be available to parents/guardians upon request. Additionally, medication policies, procedures, and forms shall be available in school handbooks.

Legal Reference

Wis. stats. 118.125 (Pupil Records), 118.29 (Medication Administration), 121.02(1)(g) (School District Standards), 146.81-46.83 (Patient Health Care Records), and 441 (Wisconsin Nurse Practice Act); Wis Admin. Code PI 8.01(2)(g)(Emergency Nursing Services).

Source: Adapted with permission from the Horicon (WI) School District, "Administration of Medications to Students Procedure (revised), January, 1997.

Abuse Reporting: Basic Elements of School District Policies

Legal Elements

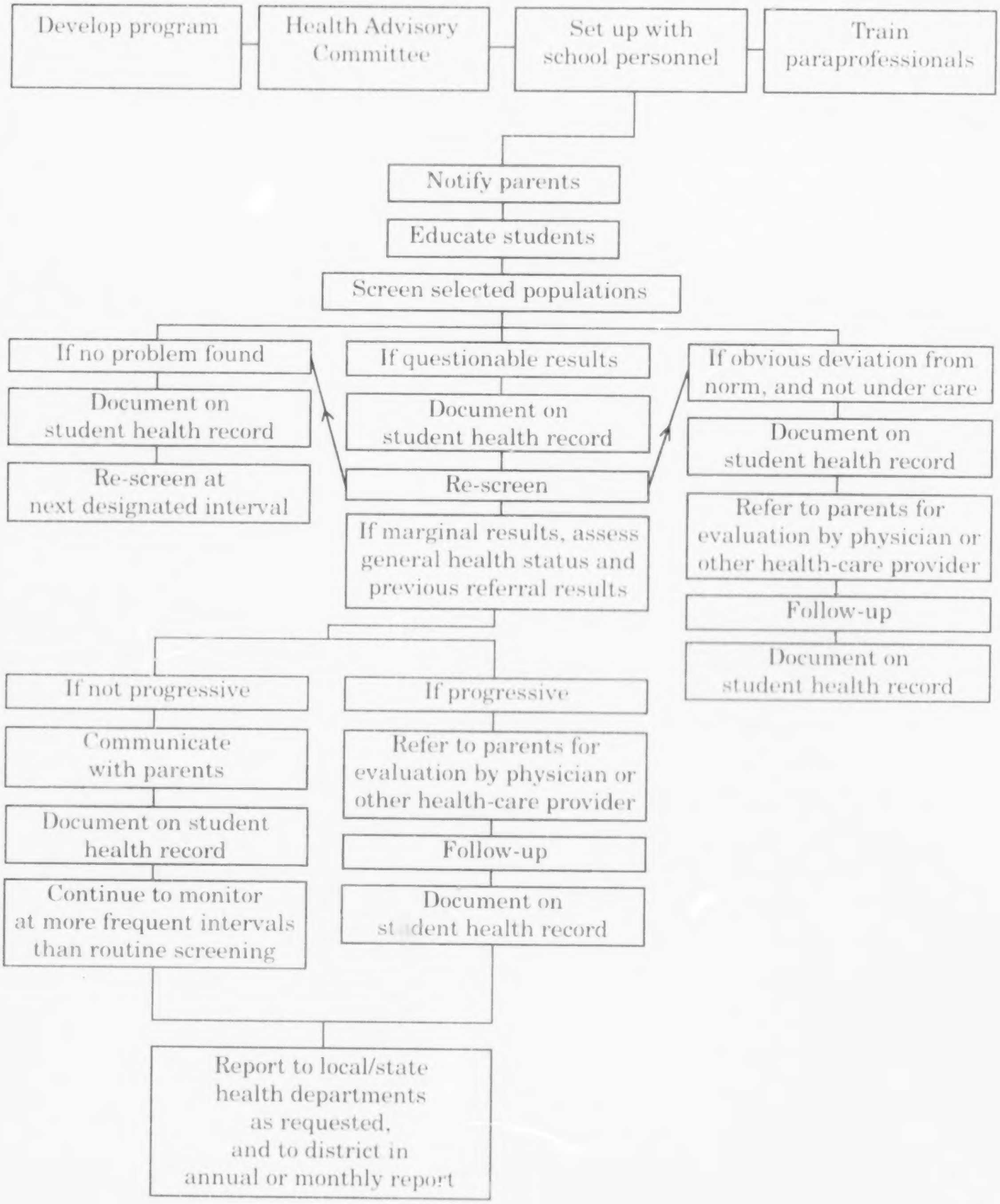
- ☐ The exact language of the law regarding child abuse and neglect; defined for Wisconsin schools in Wis. stats. 48.981, 940.225, 940.227, 948.02(1)(2)(3), and 948.05.
- ☐ A description of who is mandated specifically to report and who may optimally report
- ☐ Reportable conditions as defined by law.
- ☐ A listing of the agency/agencies legally designated to receive reports.
- ☐ The information required of the reporter.
- ☐ Information on immunity for those who report "in good faith" or for those who participate in an investigation or judicial proceeding.
- ☐ The penalty for failure to report as established by law.
- ☐ Any provisions of the law regarding the confidentiality of records pertaining to reports of suspected abuse or neglect.

Transitional Elements

- ☐ The expected professional conduct of school employees.
- ☐ A brief rationale for involving school personnel in reporting.
- ☐ The method and procedures by which school personnel are to report and the time in which they must report.
- ☐ Action taken by the school board for failure to report.
- ☐ Information listing some indicators of child abuse and neglect that will assist mandated reporters in fulfilling their responsibilities.
- ☐ A determination of how records of reported cases will be kept.
- ☐ The way the district will collaborate with community child protection and law enforcement agencies.
- ☐ The way the district attorney will conduct yearly staff inservices on child abuse and neglect reporting.
- ☐ The way the district will inform the public of its reporting policy.
- ☐ The way the child abuse and neglect policy will be evaluated.

Source: Wisconsin Department of Public Instruction. Child Abuse and Neglect Prevention: A Resource and Planning Guide. *Madison: WDPI, 1993.*

Screening Program Flowchart and Description


Develop program
Health Advisory Committee
Set up with school personnel
Train paraprofessionals
Notify parents
Educate students
Screen selected populations
If no problem found
Document on student health record
Re-screen at next designated interval
If questionable results
Document on student health record
Re-screen
If marginal results, assess general health status and previous referral results
If obvious deviation from norm, and not under care
Document on student health record
Refer to parents for evaluation by physician or other health-care provider
Follow-up
Document on student health record
If not progressive
Communicate with parents
Document on student health record
Continue to monitor at more frequent intervals than routine screening
If progressive
Refer to parents for evaluation by physician or other health-care provider
Follow-up
Document on student health record
Report to local/state health departments as requested, and to district in annual or monthly report

The following information provides a framework that applies to the development of any school- or community-based appraisal program.

Assessment

The scope and nature of an appraisal program should be based on the documented health needs of the population served. These needs may be identified by a state agency and may, by statute or regulation, be required to be addressed by school or community health personnel, parents, students, or educators.

Decisions to conduct appraisal programs should be based on whether

- the target population that is at risk for developing an illness/condition is not likely to be detected unless the screening is offered;
- the condition is relatively prevalent, and early treatment will improve the outcome;
- the appraisal procedure is reliable, simple, and inexpensive;
- referral to local community resources can be handled in an efficient manner; and
- financial resources are available to assist needy families.

Program planners should be wary of efforts to implement appraisals of students (a captive population) which is unlikely to offer any health benefit.

Planning

Careful planning is the key to an effective appraisal program. Time invested during the planning phase will make implementation easier and more accurate. School nurses should provide leadership in the planning phase and will need to spend the required time to develop a successful school-based program.

The following issues should be addressed during the planning phase:

- Determine the objectives of the appraisal program and the evaluative outcome criteria (EOC).
- Criteria that focus on the results/outcomes of the program, measure behaviors, and give dates by which behaviors occur.
- Define the population to be screened.
- Decide which appraisal procedure(s)/test(s) will be used.
- Ensure adequate resources, including funding for equipment, supplies, staff, training, and personnel, are available .
- Ensure adequate time to record results; interpret results for students, families, and teachers; and conduct follow-up work.
- Determine referral criteria using established standards.
- Collaborate with members of the school health advisory committee regarding criteria used for referral and resources available for follow-up, especially for children who are underinsured or uninsured.

Planners should also do the following in determining the mechanics of the screening program:

- Determine the amount of time required for appraisal.
- Designate screening personnel.
- Determine who will: order supplies; ensure equipment is in working order; obtain parental consent (if required); recruit, orient, and train screening personnel; arrange for appropriate quiet, private space; record findings; rescreen students with positive findings; plan and complete follow-up procedures; determine how appraisal findings interact with the health education curriculum; and evaluate plans and report the results of the appraisal program.

Procedures

After materials, space, time, and screener training are addressed, the screening team may begin the appraisal.

- Perform the appraisal as planned.
- Document test results on school health records.
- Refer students with positive findings for follow-up by a professional licensed care provider.

- Notify parent(s)/guardian(s) by letter and, if necessary, by telephone of children with positive findings and recommend further evaluation by an appropriately licensed professional care provider.
- Notify the medical provider by letter, usually through a parent, of appraisal findings and request feedback based on their evaluation.

Follow-up

Follow-up is critically important for any appraisal program. Early diagnosis and prompt treatment can affect remediation of the problem before it progresses and is more costly to treat. The school nurse will want to prepare for the follow-up steps:

- Obtaining reports/feedback from the medical provider or related professionals (such as audiologists or optometrists) regarding diagnosis, treatment, follow-up care, and any educational adjustments/modifications to be implemented by school personnel.
- Continuing contact with parents, including telephone calls or home visits, until all follow-up recommendations are implemented.
- Interpreting findings for students, families, and teachers.
- Documenting in school health records any conditions, treatments, follow-up care, and educational adjustments or modifications to be carried out by school personnel.
- Ensuring the confidential handling of data.

Evaluation

A good deal of informal evaluation goes on throughout all phases of the program. For example, if the established screening traffic/routing pattern proves to be inefficient, the pattern can be altered to correct the problem without waiting for the formal program evaluation.

Formal program evaluation is usually conducted after the appraisal program is completed. It is generally based on two major components: achievement of the stated objective(s) and the evaluative outcome criteria. Both areas merit careful review and assessment, because the results of the evaluation provide feedback to the planning phase. As an example, consolidating data by grade, comparing results to expected results based on national or state data, and comparing completed referrals to the established goal provides data necessary for the evaluation phase. If program objectives and EOC's were not achieved, than inference and analysis will be useful in determining the cause. Analysis of nonachievement can provide useful insights into program weaknesses and should be carefully considered when the program is revised.

School-Age Child Health Concerns Inventory

UW-Eau Claire School of Nursing

R 1 2 3 4 5

Name ______________________ Age ________ Grade ________ Sex: M ☐ F ☐

Health Concerns: Think about your body and how healthy it is. Check any concerns you have in the way you feel.

General

1. Poor appetite ☐
2. Too much appetite ☐
3. Too much thirst ☐
4. Too fat ☐
5. Too thin ☐
6. Too short ☐
7. No energy ☐
8. Too much energy ☐
9. Too tired ☐
10. Eats nonfood items ☐

Skin

11. Rash ☐
12. Itching ☐
13. Very dry skin ☐
14. Warts ☐
15. Many bruises ☐

Eyes

16. Blurry or fuzzy vision ☐
17. See double ☐
18. Can't see blackboard ☐
19. Eyes hurt, itch, or water ☐

Ears, Nose, and Throat

20. Can't hear ☐
21. Earaches ☐
22. Sore throats ☐
23. Toothaches ☐
24. Bad teeth ☐

Chest and Abdomen

25. Wheezing ☐
26. Too short of breath ☐
27. Chest hurts ☐
28. Too many stomachaches ☐
29. Abdominal pain ☐
30. Constipation (hard stool) ☐
31. Stool (poop) in pants ☐

Kidneys and Bladder

32. Hurts to go to bathroom ☐
33. Have to go too often ☐
34. Wet pants ☐
35. Wet bed ☐

Bones and Muscles

36. Leg aches ☐
37. Swollen/sore joints ☐
38. Back pain ☐
39. Limp ☐

Brain and Nerves

40. Too many headaches ☐
41. Feel weak, dizzy ☐
42. Fall for no reason ☐
43. Fainting ☐
44. Clumsy ☐
45. Day dreaming ☐
46. Miss part of directions ☐

Social/Feelings

47. No friends ☐
48. Bad dreams ☐
49. Scared/fears ☐
50. Sad ☐
51. Lonely ☐
52. Too much anger ☐
53. Cry too much ☐

☐ I do not have any of the concerns listed above

☐ I would like to talk to my school nurse about one or more of the checked concerns.

When not in school, I like to: ______________________

____

My chores at home are: ______________________

____

I watched ________ TV programs yesterday.

I like to play with:

One friend ☐ My family ☐
A group of friends ☐ Alone ☐

Check the kinds of exercise you like:

Jumping rope ☐ Playing ball ☐
Swimming ☐ Riding bicycle ☐
Hiking ☐ Skating ☐
Skiing ☐ Jogging ☐

Source: Reprinted with permission from MacBriar, B., et al. Development of Self-Assessment Health Inventory for School-Age Children. *Eau Claire: University of Wisconsin-Eau Claire, School of Nursing, 1995.*

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Blood Pressure Screening

Definition: Blood pressure is the pressure blood places on the walls of the arteries, primarily maintained by the contraction of the left ventricle of the heart. (NHBPEP, 1996; NIH, 1997)

Normal: systolic and diastolic blood pressures less than the 90th percentile for age and sex

High Normal: average systolic and/or diastolic blood pressures between the 90th and 95th percentile for age and sex

High: average systolic and/or diastolic blood pressures greater than or equal to the 95th percentile for age and sex with multiple measurements obtained on repeated visits over weeks or months.

If the blood pressure reading is high normal for age but can be accounted for by excess height for age or excess lean body mass for age, such children are considered to have normal blood pressure.

Purpose: To provide an index of circulatory system functioning (elasticity of the arterial walls, peripheral vascular resistance, efficiency of the heart as a pump, and blood volume).

Equipment: The equipment needed to measure blood pressure in children ages three through adolescence includes a stethescope, sphygmomanometer, and three pediatric cuffs of differing sizes as well as standard and oversized adult cuffs; the latter may be needed for obese children or adolescents.

Documentation: Vital signs can be documented on a flowchart or treatment record. Whenever there is a change in the student's health status, the nurse should document changes in vital signs in the student's health record. Record the reading on the blood pressure flowchart and blood pressure graph. Compare it with previous values. Record 1st phase/5th phase and indicate: the student's position (laying [L], standing [St], sitting [Si]); which limb was used (right arm [RA], left arm [LA], right leg [RL], left leg [LL]); and the size of the blood pressure cuff.

Procedure

☐ Determine the need to measure the student's blood pressure. Review nursing procedures and the student's health plan.

☐ Prepare a quiet, private, nondistracting setting, if possible, as blood pressure can be affected by environmental and biological factors as well as medications.

☐ Assemble equipment.

☐ Tell the student you are going to measure his/her blood pressure. (Note: Use developmentally appropriate language and allow the student, if so desired, to handle the equipment before the blood pressure is measured. Blood pressure should be measured in a controlled environment, after 3-5 minutes of rest in a seated position with the cubital fossa supported at heart level.)

☐ Have the student sit, then extend a fully-exposed arm, palm up, on a supportive surface. This facilitates placement of the cuff at heart level. (Note: For consistency, use the same limb at approximately the same time of day each time you measure a given student's blood pressure.)

☐ Apply an appropriately sized cuff snugly to the upper arm, centering the cuff's bladder over the artery and leaving a space of one inch above the antecubital area for placement of the stethoscope. (Note: The size of the cuff is determined by the person's size, not age. The 1987 Report of the Second Task Force on Blood Pressure Control in Children recommends that the cuff cover no less than one-half (1/2) and no more than two-thirds (2/3) of the upper arm. The bladder within the cuff should encircle the girth of the arm without overlapping or leaving a gap. There also must be enough room at the upper edge of the cuff to prevent obstruction of axilla. A cuff that is too narrow will cause an apparent rise in blood pressure; one that is too wide will produce an apparent drop. Folding a flexible cuff to the correct size may be easier and more effective than using a premeasured cuff that is "almost" right. The cuff should be of consistent width each time the blood pressure is measured. One technique used to establish an appropriate cuff size is to choose a cuff having a bladder width that is about 40% of the arm circumference midway between the olecranon and the acromian process. This will usually be a cuff bladder that will cover 80% to 100% of the circumference of the arm. Use the manufacturer's lines on the cuff to select the correct cuff size for a given child.)

☐ Palpate the brachial artery and inflate the cuff until the palpated pulse is lost; note this value on manometer. (Note: This eliminates the ascultatory gap or the temporary disappearance of second-phase blood pressure sounds.)

☐ Pump for an additional 20mm of mercury (Hg) beyond the previously noted point; note this value.

☐ Deflate the cuff slowly and completely; wait about one (1) minute, while the student relaxes.

☐ Rapidly reinflate the cuff to about the point that included the additional 20mm Hg beyond the point the radial pulse disappeared.

☐ With earpieces in place, apply the stethoscope over the brachial artery using the bell or diaphragm.

☐ Holding the stethoscope in place, release the cuff pressure at an approximate rate of 2mm Hg/second. (Note: Faster release of pressure will result in inaccurate readings.)

☐ Read Hg gravity manometer at eye level. As pressure is released, the phases (I to V) of "Korotkoff Sounds" will be heard. (Note: Korotkoff Phase I is marked by the first appearance of faint, clear tapping sounds which gradually increase in intensity (systolic pressure). Phase II is the period in which a murmur of a swishing quality is heard. Phase III is the period in which sounds are crisper and increase in intensity. Phase IV is marked by a distinct, abrupt, muffled sound so that a soft, blowing sound can be heard. Phase V is the point at which sounds disappear. In children, phases IV and V frequently occur simultaneously, and often Phase V is not apparent. The American Heart Association has established Phase V as the definition of diastolic pressure.)

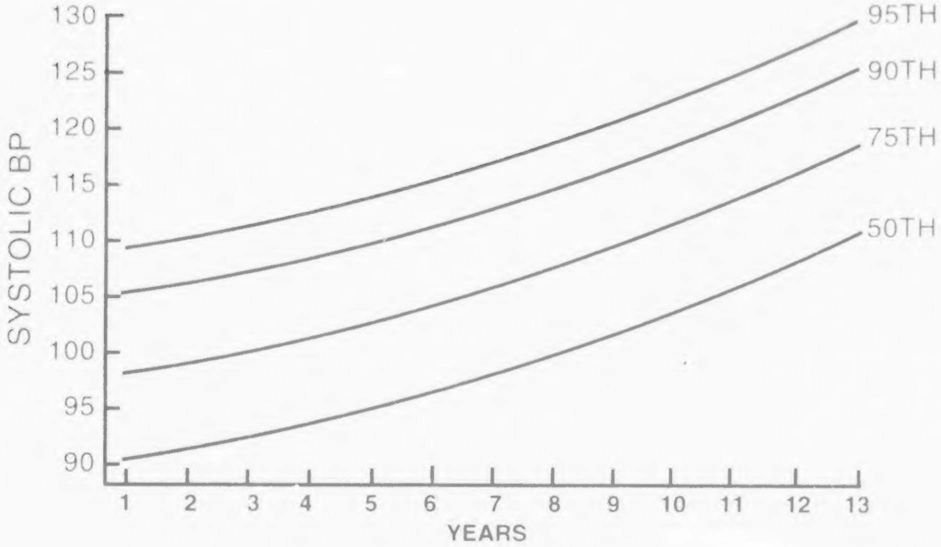
☐ Record the student's blood pressure reading. The student's blood pressure should be recorded at least twice on each occasion, and the average of each systolic and diastolic measurement should be used to estimate the blood pressure level. (Note: Be sure to record the date, time, size of cuff, and on which arm/leg the measurement was taken. Record any observations about the student's appearance and behavior during the course of the reading. Example: BP=104/60/54mm Hg, RA (right arm), sitting, child cuff.)

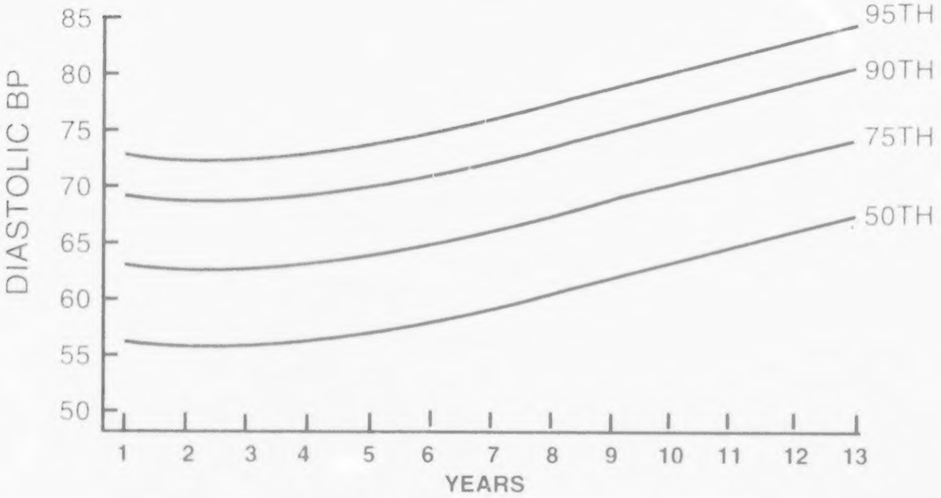
☐ If the results are within normal limits, have the student return to scheduled classroom activities. If the results are abnormal, refer to the student's health plan or to the nursing protocol. (Note: Elevated blood pressure must be confirmed on repeated visits before characterizing an individual as having hypertension. Indeed, high blood pressure levels tend to fall with subsequent measurement because of reduced anxiety and a natural variation in levels even under constant conditions.)

☐ Inform appropriate school staff members of the benefits of blood pressure monitoring in school. (Note: This helps optimize the student's performance and effectively report any relevant changes they may observe.)

☐ Summarize the apparent benefit or lack of benefit to the student in having his/her blood pressure monitored in school. (Note: Also provide this information to the student's parent(s)/guardian(s) and authorized prescriber on a periodic basis or as indicated in the health care plan.)

Blood Pressure Measurements—Boys 1-13 Years



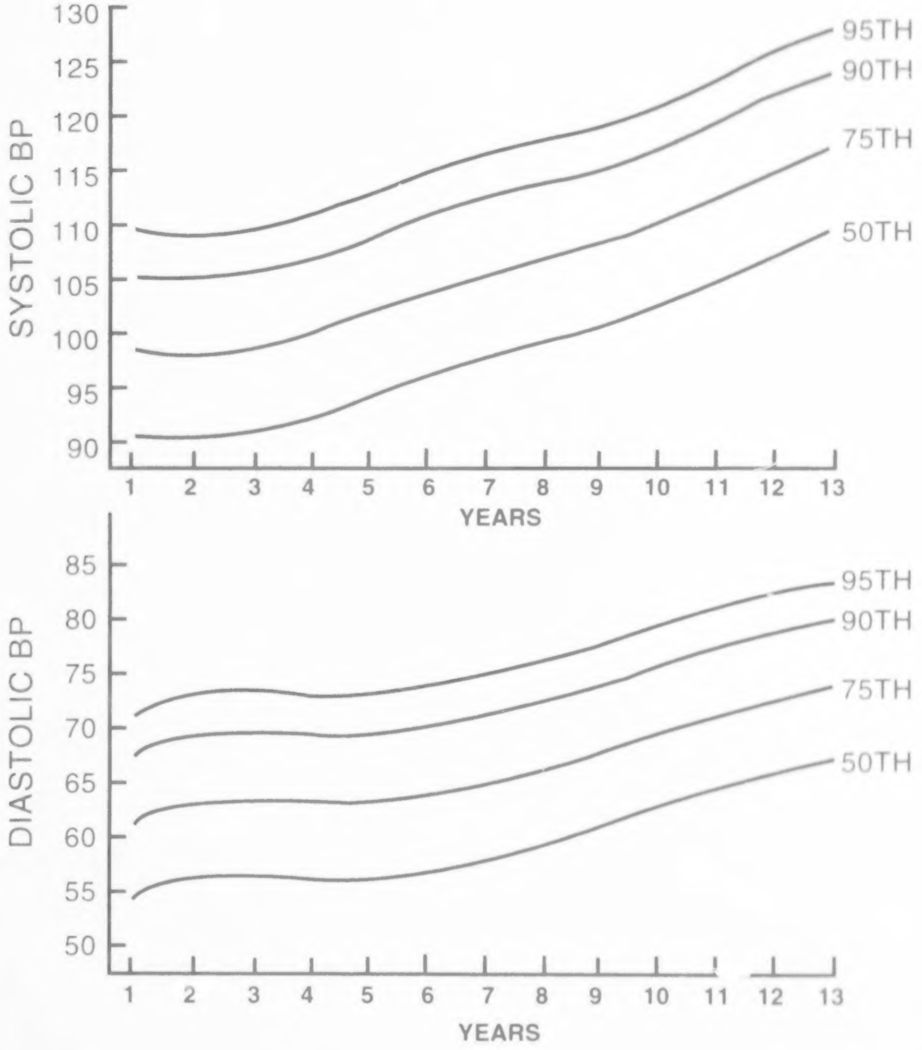


90TH PERCENTILE													
SYSTOLIC BP	105	106	107	108	109	111	112	114	115	117	119	121	124
DIASTOLIC BP	69	68	68	69	69	70	71	73	74	75	76	77	79
HEIGHT CM	80	91	100	108	115	122	129	135	141	147	153	159	165
WEIGHT KM	11	14	16	18	22	25	29	34	39	44	50	56	62
YEARS	1	2	3	4	5	6	7	8	9	10	11	12	13

Source: Report of the Second Task Force on Blood Pressure Control in Children, U.S. Department of Health and Human Services, P.H.S., NIH. 1987

VI-6-27

Blood Pressure Measurements—Girls 1-13 Years

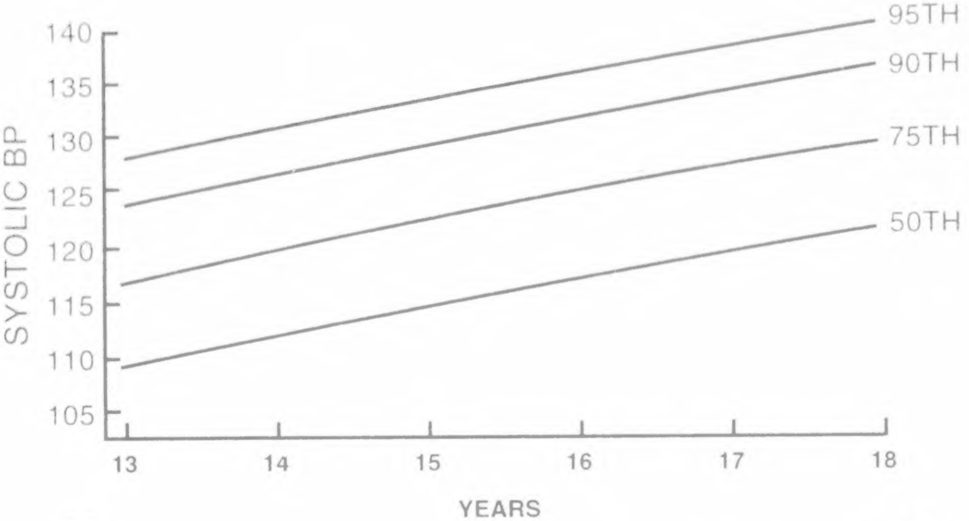


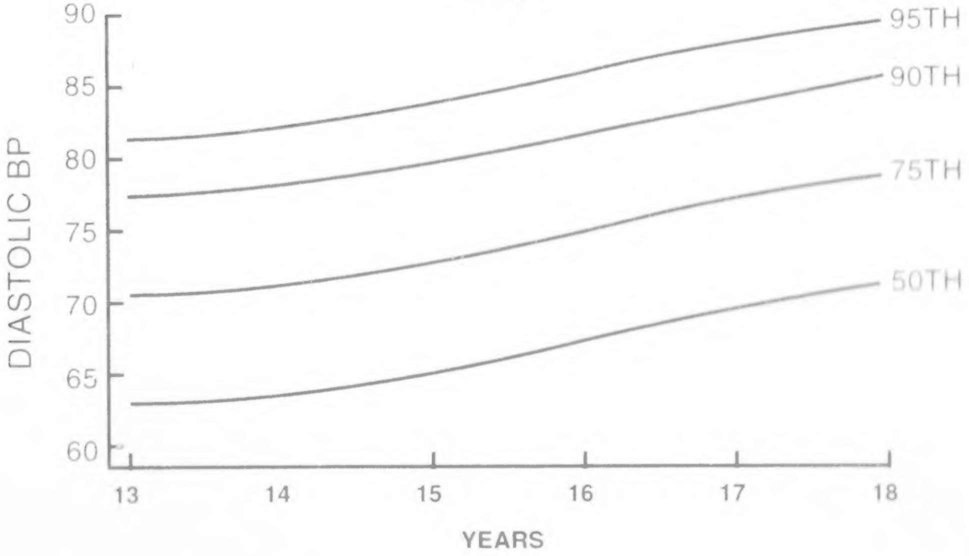
90TH PERCENTILE													
SYSTOLIC BP	105	105	106	107	109	111	112	114	115	117	119	122	124
DIASTOLIC BP	67	69	69	69	69	70	71	72	74	75	77	78	80
HEIGHT CM	77	89	98	115	115	122	129	135	142	148	154	160	165
WEIGHT KM	11	13	15	22	22	25	30	35	40	45	51	58	63
YEARS	1	2	3	4	5	6	7	8	9	10	11	12	13

Source: Report of the Second Task Force on Blood Pressure Control in Children. U.S. Department of Health and Human Services, P.H.S., NIH, 1987.

VI-6-25

Blood Pressure Measurements—Boys 13-18 Years



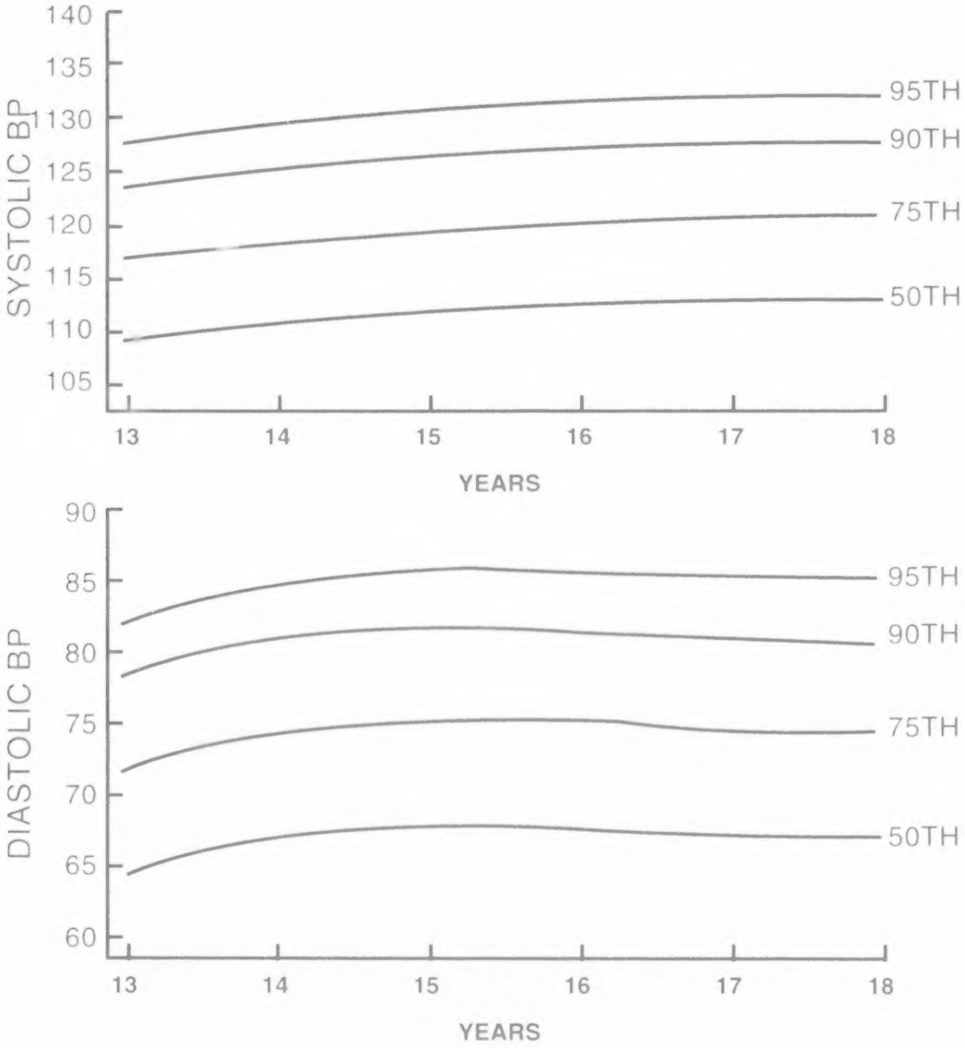


90TH PERCENTILE

SYSTOLIC BP	124	126	129	131	134	136
DIASTOLIC BP	77	78	79	81	83	84
HEIGHT CM	165	172	178	182	184	184
WEIGHT KM	62	68	74	80	84	86
YEARS	13	14	15	16	17	18

Source: Report of the Second Task Force on Blood Pressure Control in Children, U.S. Department of Health and Human Services, P.H.S., NIH, 1987 VI-6-26

Blood Pressure Measurements—Girls 13-18 Years



90TH PERCENTILE						
SYSTOLIC BP	124	125	126	127	127	127
DIASTOLIC BP	78	81	82	81	80	80
HEIGHT CM	165	168	169	170	170	170
WEIGHT KM	63	67	70	72	73	74
YEARS	13	14	15	16	17	18

Source: Report of the Second Task Force on Blood Pressure Control in Children, U.S. Department of Health and Human Services, P.H.S., NIH, 1987

VI 6-24

Blood Pressure Screening Referral

Dear Parent:

Blood pressure screening is one of the preventive health services provided by the School Health Program in this district. Your son's/daughter's class was recently screened as part of a health awareness initiative.

It is recommended that he/she be seen by a physician because his/her blood pressure was elevated at three different times. The readings are as follows:

	Date of Screening	Blood Pressure Reading	Arm Used	
1.	________	________	Rt. ______	Lt. ______
2.	________	________	Rt. ______	Lt. ______
3.	________	________	Rt. ______	Lt. ______

Please have ____________ (student's name) examined by his/her doctor. Ask the doctor to complete the bottom portion of this form and return it to the school nurse by ____________.

Nurse	Phone *Area / No.*
School	Date of Referral

Physician's Report of Blood Pressure Examination

Name of Student	Do you wish to have this student's blood pressure monitored at school? ☐ No ☐ Yes *If yes, how often* ______

Examination Findings

Recommendations and/or treatment

Physician's Name	Office Phone *Area / No.*
Physician's Signature	Date Signed

Please return this form to the school nurse listed above.

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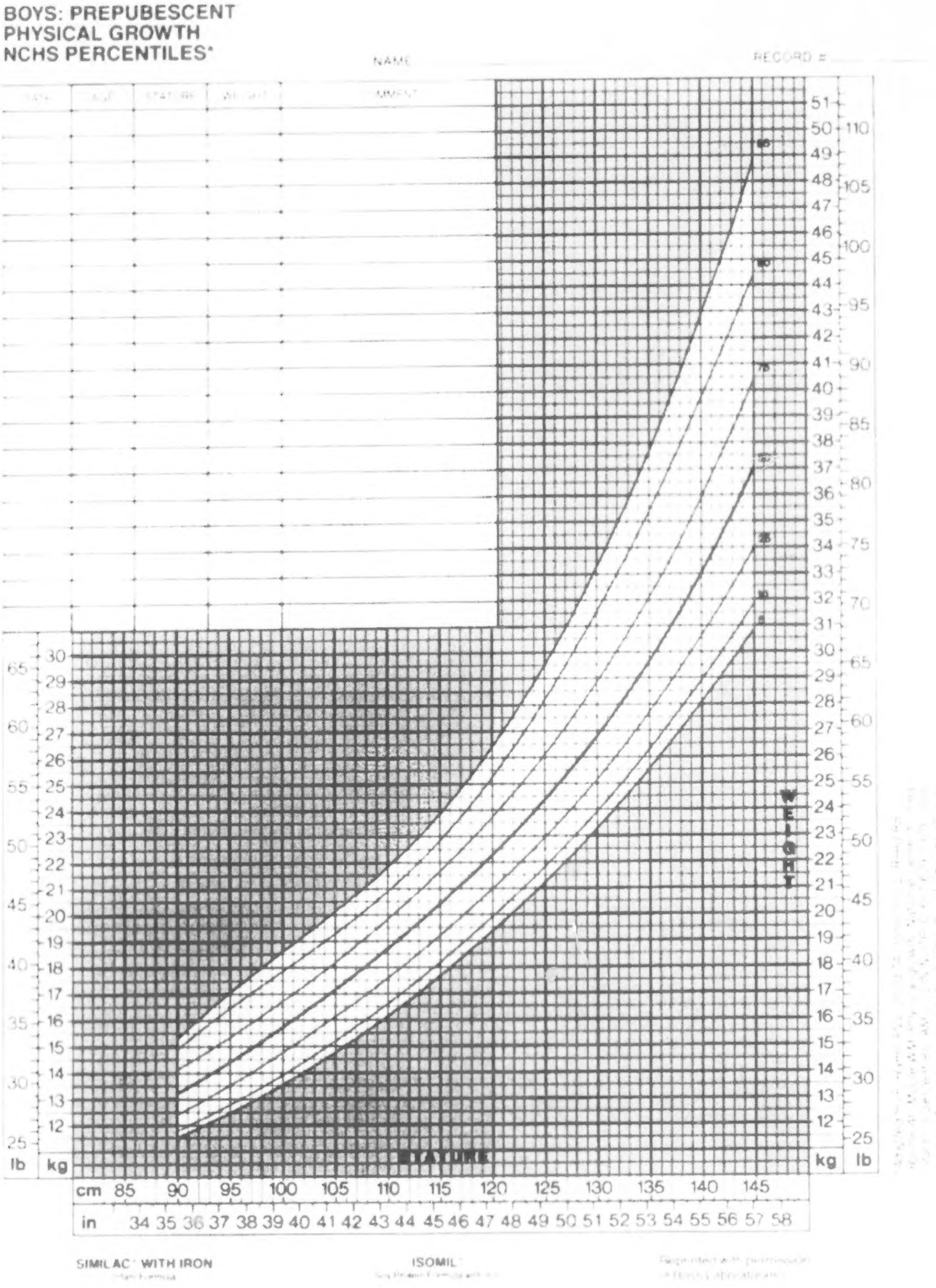
Height and Weight Measurement—Prepubescent Boys



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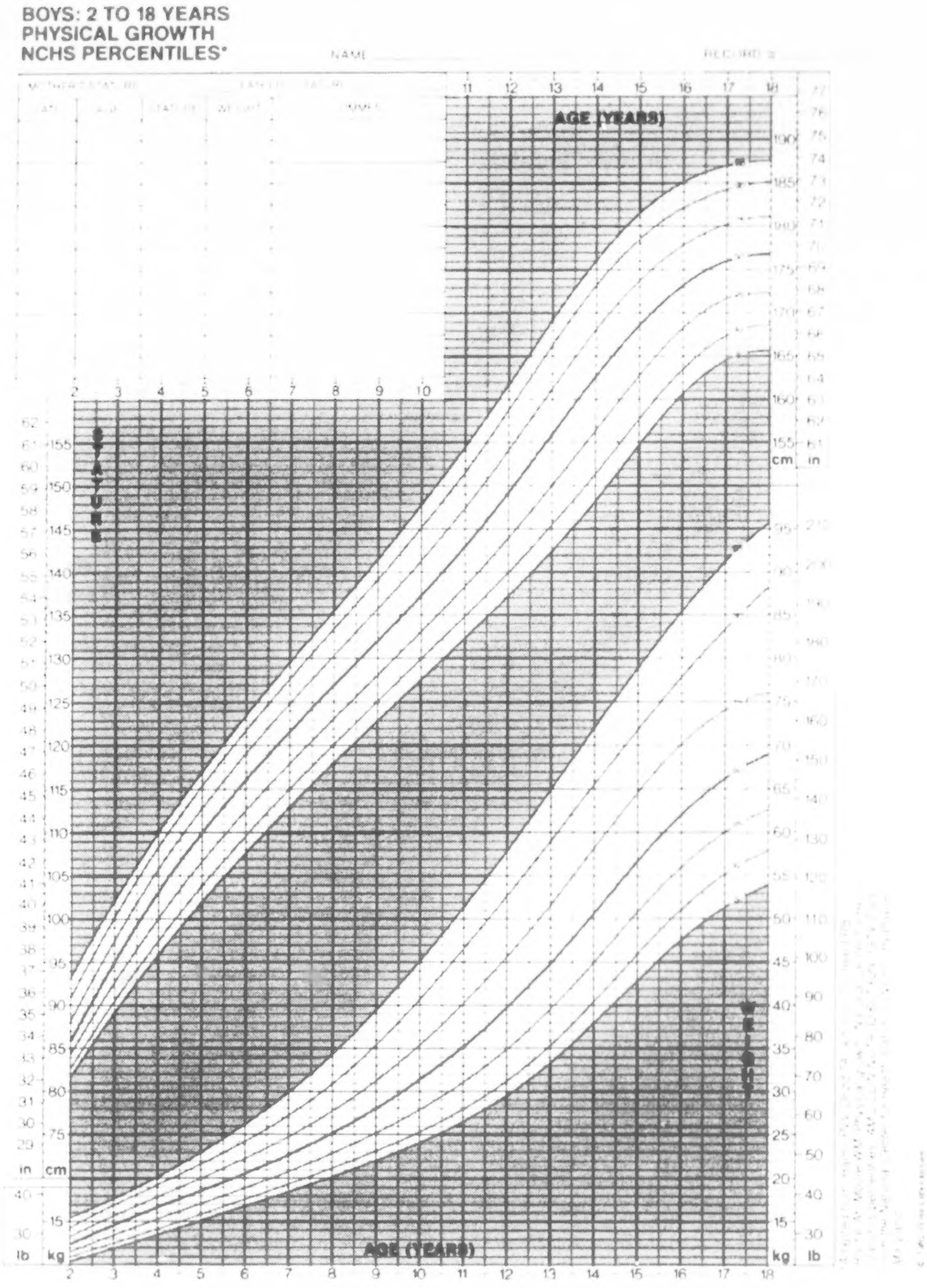
Height and Weight Measurement—Boys 2-18



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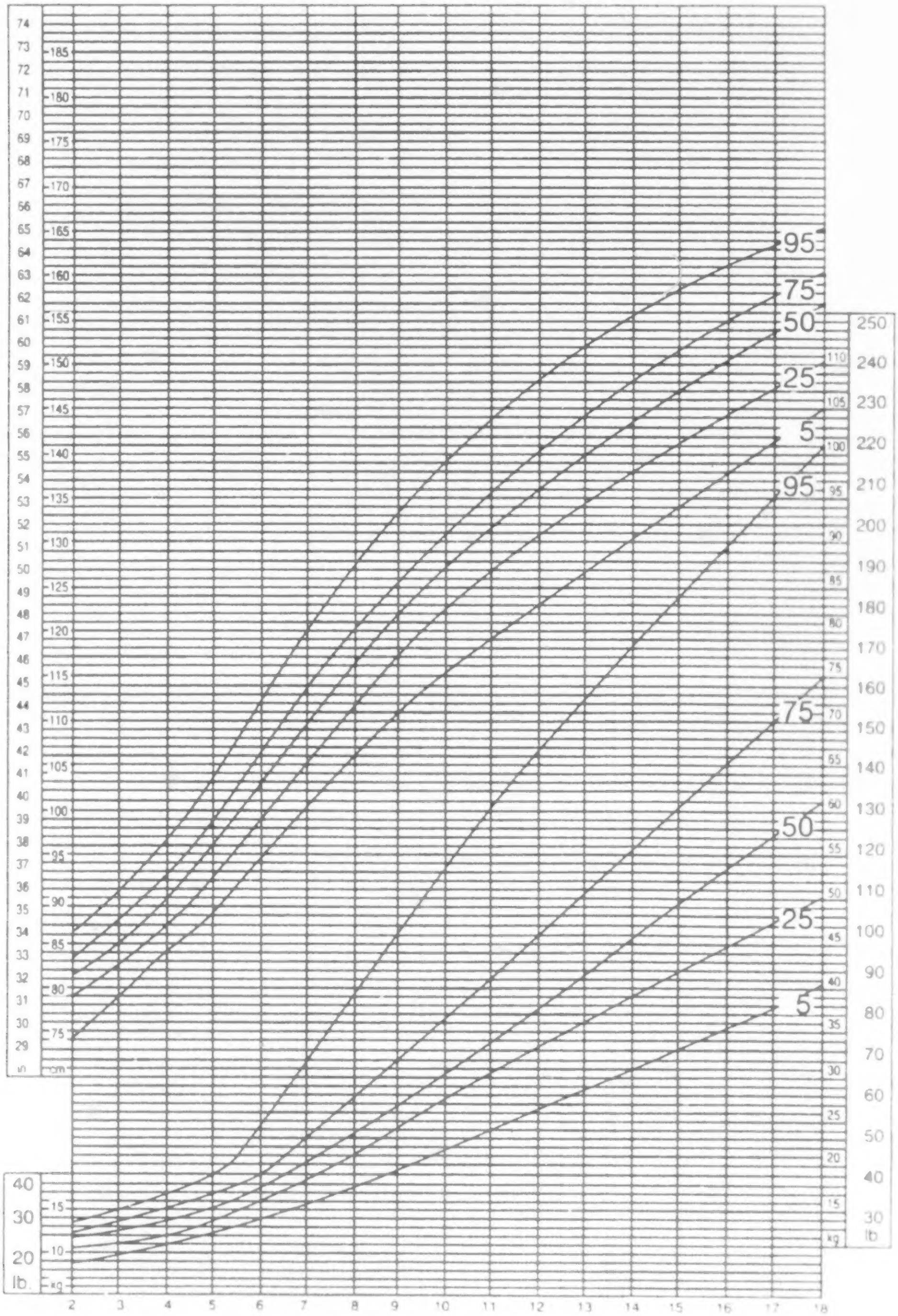
Height and Weight Measurement—Down's Syndrome Boys 2-18 Years



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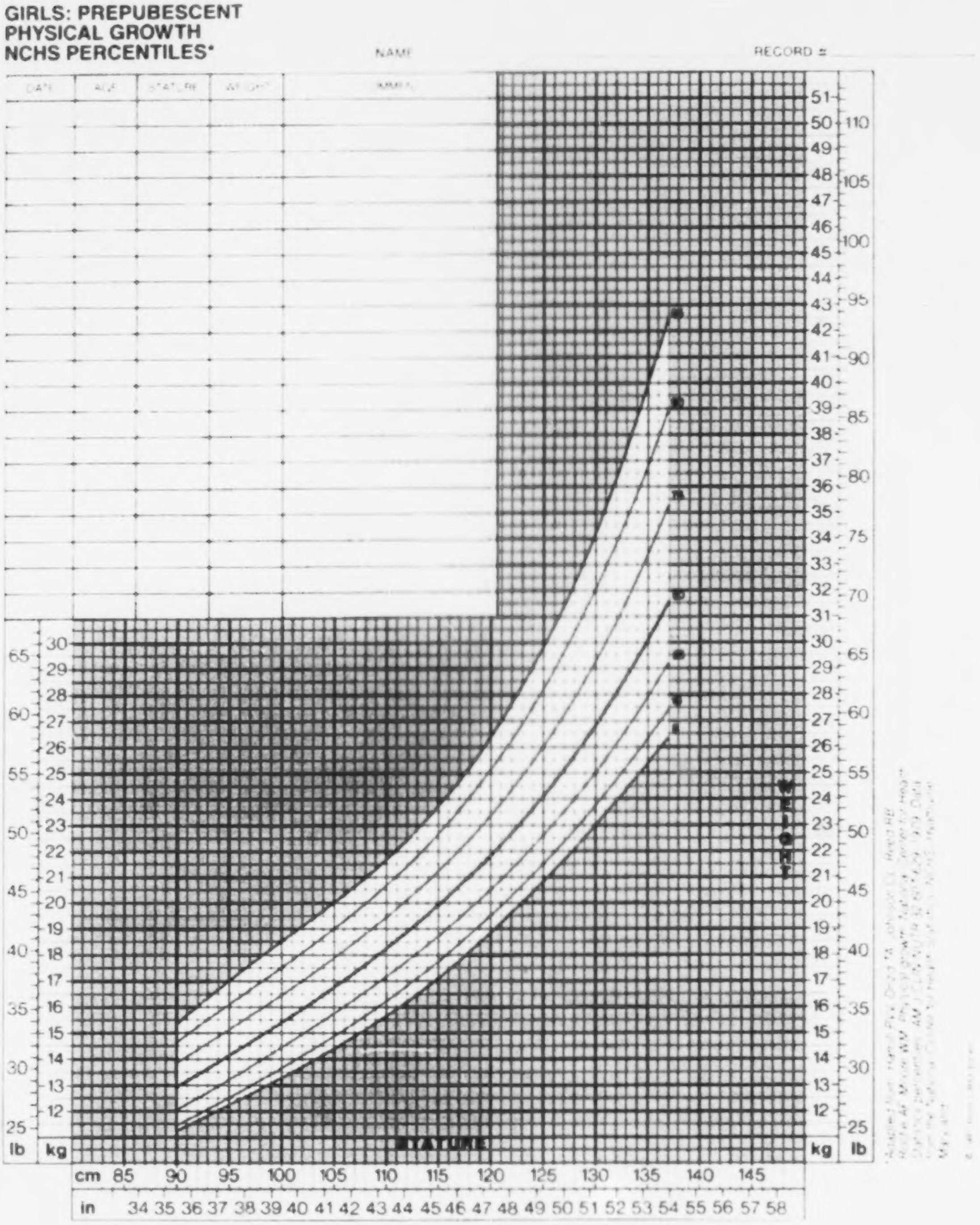
Height and Weight Measurement—Prepubescent Girls



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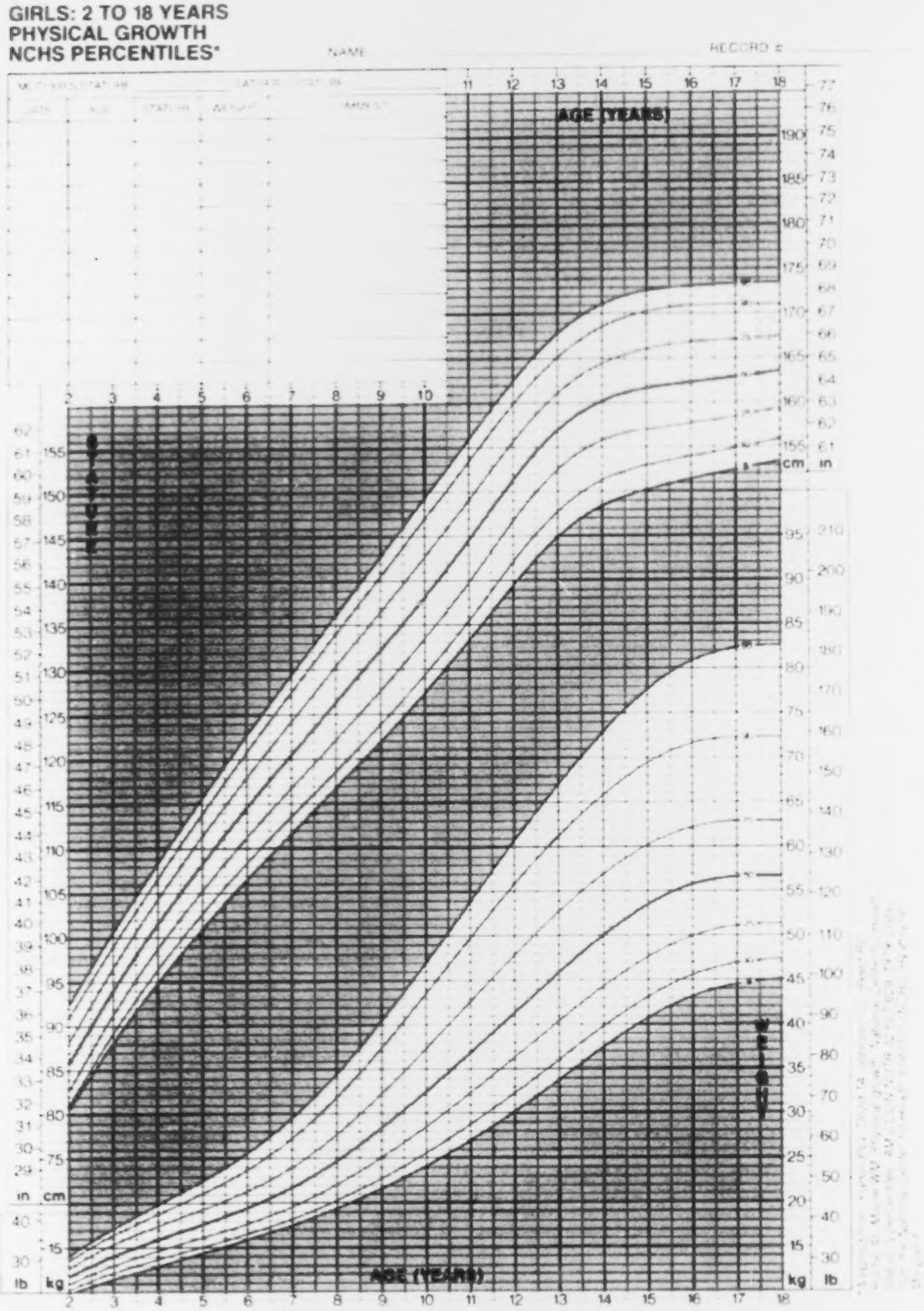
Height and Weight Measurement—Girls 2-18 Years



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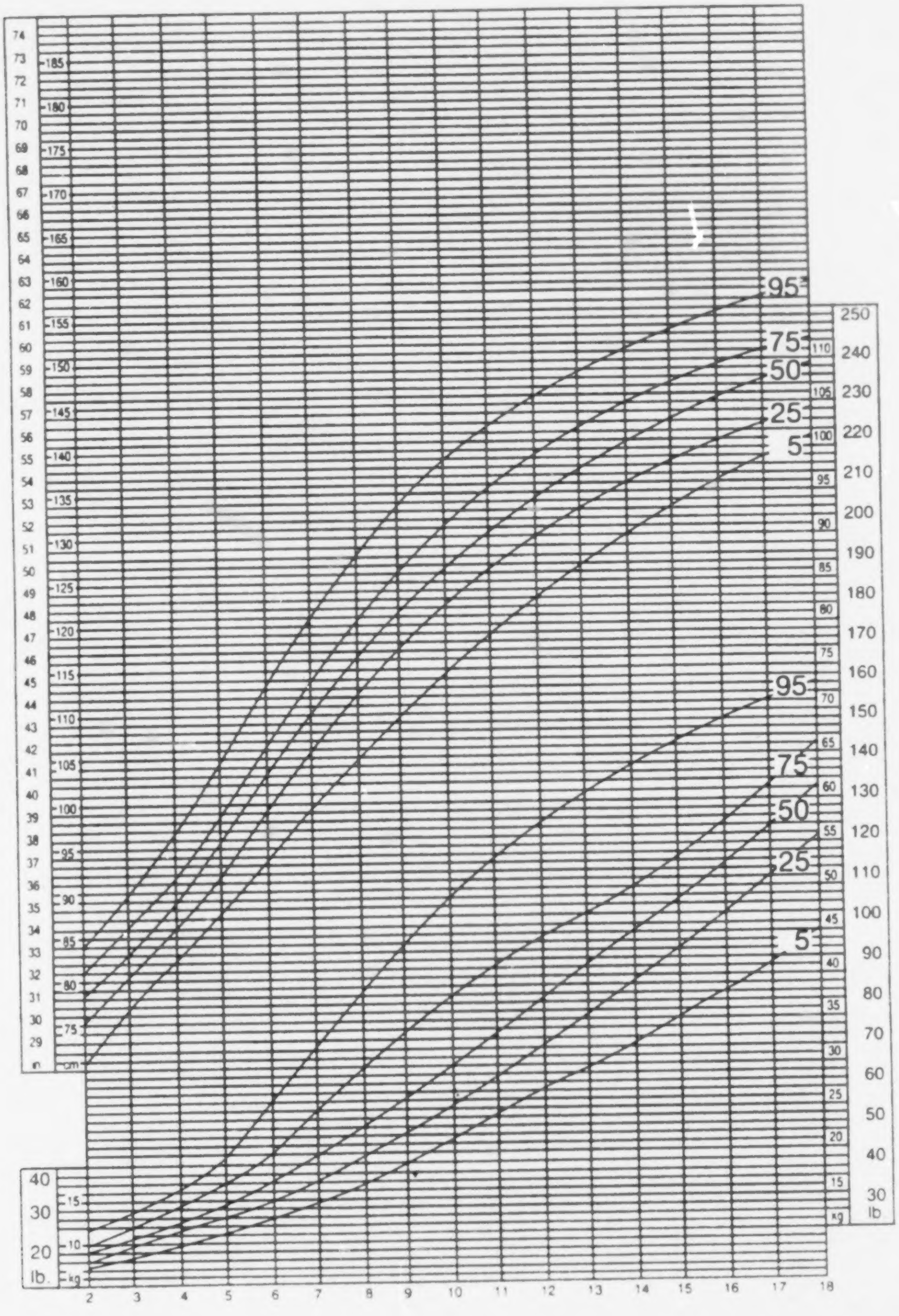
Height and Weight Measurements— Down's Syndrome Girls 2-18 Years



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Height and Weight Screening

Height

Definition: *Height* is the measure from the bottom of the heel to the top of the head.

Purpose: To monitor growth and evaluate treatment.

Equipment: Measuring scale marked in one-eighth (1/8) inch increments witha six (6) inch head board capable of being extended at a right angle to the measuring scale, which should be mounted to a vertical, flat surface (wall). All equipment should be calibrated annually.

Precautions: Ensure student safety.

Documentations: Document height on Growth Chart. Any alteration in the student's health status or health-care plan should be documented by the school nurse in the student's health record.

Procedure: Standing

☐ Have the student remove his/her shoes, then stand at the measuring scale.

☐ Ask the student to "stand tall"; look straight ahead; and place shoulder blades, buttocks, and heels against the measuring tape while keeping heels flat to the floor. Check the student's body alignment to ensure this has been done properly.

☐ Lower the headboard until it firmly rests on the crown of the student's head, creating a right angle to the vertical measuring surface.

☐ Determine the student's height to the nearest one-eighth (1/8) inch, based on the point at which the headboard meets the measuring tape. If appropriate, privately inform the student of the results.

☐ Graph the result on the student's age-appropriate growth chart. Record the height with percentiles on the student's health record.

☐ Compare the student's measurement with previous measurements to assess any pattern and/or change.

Procedure: Lying Down

☐ Ask the student to lay on his/her back (the "supine" position) on the measuring board with shoes off.

☐ Ask the student to extend his/her body as fully as possible. Place student's shoulder blades, buttocks, and heels against the measuring tape/board. Check the student's body alignment to ensure this has been done properly.

☐ Have an assistant hold the student's head against the board; ask the student to look at the ceiling.

☐ Determine the student's height to the nearest one-eighth (1/8) inch, based on the point at which the footboard meets the heel and measuring board. If appropriate, privately inform the student of the results.

☐ Graph the result on the student's age-appropriate growth chart. Record the length with percentiles on the student's health record.

☐ Compare the student's measurement with previous measurements to assess any pattern and/or change.

Weight

Definition: *Weight* is the measure of the heaviness or mass of a student.

Purpose: To monitor growth and evaluate treatment.

Equipment: A beam balance scale with a platform and nondetachable free-sliding weights. The scale should be marked in one-quarter (1/4) pound increments and must have a zeroing adjustment. Spring balance scales are not recommended because of progressive loss of accuracy and increments generally greater than one-quarter (1/4) pound. Wheelchair platform scales are recommended for nonambulatory students.

Precautions: Ensure student safety. Students should be on the scale without assistance while measurements are being taken. Should a student have an orthosis, prosthesis, or wheelchair, every effort should be made to weigh the equipment seperately; that weight should then be subtracted from the combined weight of the student with the equipment.

Documentation: Document weight on Growth Chart. Any alteration in the student's health status or health-care plan should be documented by the school nurse in the student's health record.

Procedure: Standing

☐ Place scale on a firm, uncarpeted surface in a private setting.

☐ Check scale for zero balance by placing both weights directly on zero while the scale is empty. To adjust, turn the zeroing weight or screw until the arrow on the right-hand side of the scale is aligned with the center mark. This procedure should be done weekly, immediately after the scale is moved, and at the beginning of a weight screening session.

☐ Ask the student to remove his/her shoes and any extraneous or heavy nonessential clothing. Every effort should be made to have students wear similarly-weighted clothes each time they are assessed.

☐ Ask the student to stand tall in the center of the scale platform with hands at the side. Leaning on the edge of the platform and wiggling can result in an inaccurate reading.

☐ Adjust the weights until the arrow on the right-hand side of the scale is aligned with the center mark. To ensure accuracy, obtain a second reading. The readings should be within one-quarter (1/4) pound of each other. If appropriate, privately inform the student of the results.

☐ Return the weights to the zero position, then ask the student to step off the scale.

☐ Graph the result on the student's age-appropriate growth chart. Record the weight with percentiles on the student's health record.

☐ Compare the student's measurement with previous measurements to assess any pattern and/or change.

☐ If necessary, ask the student to re-dress or assist as necessary.

☐ If the results are abnormal, follow the student's health care plan or nursing protocol.

Source: Wong, D., and L. Whaley. Clinical Manual of Pediatric Nursing *(4th ed.). St. Louis, MO: Mosby Year Book. 1996, pp. 28-31.*

Instructions for Performing the Initial Audiometric Pure-Tone Hearing Screening Test

Test Room Noise Level Check

The test room must be quiet enough so that the tester or a young adult with normal hearing can clearly hear all of the test tones at the screening intensity levels specified in "PASS/FAIL CRITERIA" below. If all of the test tones cannot be heard clearly, a quieter test room must be found for screening.

Audiometer Performance Check

With the audiometer set to a loudness of 60 dB and a frequency of 2000 Hz and set to "normally on," determine that the tones reaching both earphones are steady (no static or interruptions). This should be done while the tester wiggles the earphone wires of both earphones at each end. If static or tone interruptions are heard, the audiometer must be repaired before it can be used.

Instructions to the Child

The instructions to the child should be simple and clear so that he/she knows exactly what is expected.

1. Explain that the tones will be soft and may be hard to hear.
2. Seat the child facing 45° away from the tester so that the tester can observe the child's reactions and so that the child cannot see the tester operating the audiometer.
3. Have the child place his/her hand on his/her knee while waiting for the tone.
4. Instruct the child to raise his/her hand every time he/she hears the tone even if it is very soft and difficult to hear.
5. Instruct the child to raise his/her hand as soon as he/she hears the tone.
6. Instruct the child to return his/ her hand to his/her knee when the tone stops.
7. Be sure the child knows to which ear the tones will be presented.

When the Child Is Ready for Screening

1. Expand the headband and place the red earphone on the right ear and the blue earphone on the left ear.
2. The tester should make certain that the opening in the center of the earphone is in direct line with the ear canal. Place the earphones on the child while facing her/him.
3. Adjust the earphones to the approximate size of the child's head before placing them in position. The headband should rest squarely in the center of the child's head.
4. Start with a one-second tone presentation in the right ear at 1,000 Hz. If the child raises her/his arm, allow the child to return her/his hand to her/his knee. Present the tone a second time, and if she/he does not respond, present the tone a third time. The child must respond correctly two out of three times in order to pass the screening in the right ear at 1,000 Hz.
5. Repeat the procedure in #4 for 2,000 Hz and 4,000 Hz in the right ear. Then repeat the entire three-tone sequence for the left ear. The child must pass the screening at all tones in both ears in order to pass the screening test. Remember: The intensity may be raised to 25 dB at 4,000 Hz if the child does not hear the 4,000 Hz tone at 20 dB in either ear.
6. If the child fails the screening, she/he should be rescreened by another tester immediately, if possible, or by the same tester after a short rest period. Carefully reinstruct the child before rescreening.

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Demonstration Techniques

1. Place the earphones on the table near the child, with the centers of the earphones facing the child.
2. Position the child to face you.
3. Adjust the intensity/H.T.L. dial to 110 dB and the frequency dial to 2,000 Hz.
4. Present the tone and demonstrate the desired response by raising your hand.
5. Repeat #4 and encourage the child to join you in responding. You may demonstrate softer tones by presenting tones at 70 to 80 dB.
6. Once the child is responding correctly all by herself/himself, resume the normal screening process as explained above.

Pass/Fail Criteria

1. The frequencies of 1,000 Hz, 2,000 Hz, and 4,000 Hz should be used.
2. The intensity dial (H.T.L. Dial) should be set at 20 dB.
3. The child must respond correctly two out of three times at each frequency in both ears in order to pass the test.
4. If there is no response at 4,000 HZ at 20 dB, the intensity may be raised to 25 dB. If the child still does not respond, he/she has failed the test.

Cautions

1. Do not develop a rhythmic presentation. Vary the timing of the tone presentations so that the child cannot anticipate when the next tone is coming.
2. The child should be seated facing 45° away from the tester. The child is positioned correctly when he/she cannot see the tester's hand operating the audiometer and the tester can see the side of the child's face.
3. Keep the length of the tones roughly equal. A one-second tone duration is desirable.
4. It is not necessary to tell the child the results of the screening test. Never tell a child he/she has failed the test. If a child asks about the results, simply say, "You did a good job on your hearing test today."
5. You may not be able to test some children. Some children will give false or no responses even after you have taken the time to carefully reinstruct and demonstrate the task for them (see "Demonstration Techniques" below). Be sure to report which children were untestable to the person in charge of your hearing screening program.

All children who fail the audiometric pure-tone hearing screening test should be referred for rescreening a minimum of four weeks later.

Source: Wisconsin Department of Public Instruction. Wisconsin Guide to Childhood Hearing Screening. *Madison: WDPI, 1993,* pp. 33-34

Instructions for Performing the Audiometric Pure-Tone Hearing Rescreening Test

Selecting the Test Environment

A quiet test environment is absolutely essential. A room is quiet enough if the test tones can be heard easily by a person with normal hearing. If the tester's hearing is not normal, locate a young adult with no history of hearing problems to listen to the test tones. Do not proceed with the rescreening if all the test tones cannot be heard easily. The room noise sources must be located and reduced or a quieter room must be found if the test tones cannot be heard easily.

Audiometer Performance Check

With the audiometer set to a loudness of 60 HL and a frequency of 2,000 Hz and set to "normally on," determine that the tones reaching both earphones are steady (no static or interruptions). This should be done while you wiggle the earphone wires of each earphone at both ends. If any interruption of the tone is heard, do not proceed with the rescreening until the audiometer is repaired. Next, without changing the settings of the audiometer, move the ear selector switch back and forth between "left" and "right." The tone should be equally loud in both ears if the listener's hearing is normal and if the audiometer is working properly.

Instructions to the Child

The tester's instructions to the child should be simple and clear so that he/she knows exactly what is expected.

1. Explain that the tones will be soft and may be difficult to hear.
2. Seat the child facing 45° away from the tester so that the tester can observe the child's reactions and so that the child cannot see the tester operating the audiometer.
3. Have the child place his/her hand on his/her knee while waiting for the tone.
4. Instruct the child to raise his/her hand every time he/she hears the tone, even if it is very soft and difficult to hear.
5. Instruct the child to raise his/her hand as soon as he/she hears the tone.
6. Instruct the child to return his/her hand to his/her knee when the tone stops.
7. Be sure the child knows to which ear the tone will be presented.

When the Child Is Ready for Screening

1. Expand the headband and place the red earphone on the right ear and the blue earphone on the left ear.
2. The tester should make certain that the opening in center of the earphone is in direct line with the ear canal. Place the earphones on the child while facing her/him.
3. Adjust the earphones to the approximate size of the child's head before placing them in position. The headband should rest squarely in the center of the head.
4. Let the child know how she/he is doing. Praise her/him if she/he is doing well, and reinstruct her/him if she/he is having difficulty with the task.

Demonstration Techniques

It may be necessary to demonstrate the test for some children who do not respond to the tones. Demonstration techniques are explained in the "Instructions for Performing the Initial Audiometric Pure-Tone Hearing Screening Test" (Appendix EE).

Pass/Fail and Referral Criteria

1. The frequencies of 1,000 Hz, 2,000 Hz, and 4,000 Hz should be used.
2. The audiometer loudness will be set to 20 dB HL for 1,000 and 2,000 Hz and 25 dB HL for 4,000 Hz.
3. The child must respond correctly two out of three times to pass each frequency in each ear.
4. If the child passes at 1,000 and 2,000 Hz but fails at 4,000 Hz in either ear, then test 3,000 Hz at 20 dB HL in that ear.
5. Failure at 1,000 or 2,000 Hz in either ear is a rescreening failure. Failure at 4,000 Hz only in either or both ears is not a failure but will require a retest next year.
6. Failure at 3,000 *and* 4,000 Hz in either or both ears is a rescreening failure.

Verifying the Failure

There are causes other than hearing loss for failure on the rescreening test. It is the tester's job to rule out these causes before accepting the failure. If a child fails any frequency in either ear,

1. Reposition the earphones and rescreen. The center of the earphone must be directly over the opening of the ear canal.
2. Increase the loudness of the tone failed to 60 dB HL to be sure the child understands the task and is paying attention. When it is clear that the child is paying attention and understands the task, reduce the loudness to the screening level and retest. If the child does not understand or is not paying attention, proceed to #3 below.
3. Reinstruct the child, and remind him/her that the tones are soft. If necessary, remove the earphones and repeat the demonstration activity. Be generous with your praise for correctly responding.
4. If a child cannot learn the screening task and does not respond to any 60 dB sounds, report him/her to the person in charge of your hearing screening program.

Referrals

Parents of children who fail the rescreening test should be informed of the failure and should be encouraged to obtain medical and audiological evaluations for their children. It is important that hearing screening personnel seek the results of the medical and audiological evaluations. If the hearing loss does not resolve with medical treatment, the child's school should be made aware of the problem. Periodic rescreening of children referred for medical evaluations and treatment is important to document the resolution of temporary hearing losses and the persistence of other hearing losses.

Source: Wisconsin Department of Public Instruction. Wisconsin Guide to Childhood Hearing Screening. *Madison: WDPI, 1993, pp. 35-36.*

Sample Parental Notification Letter for Hearing Screening

Date: ____________

Dear Parent/Guardian:

Your child recently participated in the school hearing screening program and failed the screening on __(date)__ and __(date)__. These results indicate that your child MAY have a hearing loss that is medically and educationally significant.

We recommend that you have your child's ears examined by a physician and his/her hearing evaluated by an audiologist as soon as possible. Early identification and treatment of a hearing problem could prevent it from interfering with your child's learning.

If you need assistance in locating providers to complete evaluations, please contact us at the address and phone number below. We may also be able to refer you to agencies or programs which can provide financial assistance for these evaluations.

At the time of your child's evaluations, please make sure that sections A and B on the enclosed form are completed. It is very important that we receive this information. Please return the completed form to the address below so that we can update your child's school health records and inform his or her teacher about a hearing loss if it exists. If your child is already under medical care for an ear problem, please ask your physician and audiologist to complete the form.

Thank you for your cooperation. Please call if you have any questions.

Name: ____________

Address: ____________

____

____

Phone Number: ____________

Source: Wisconsin Department of Public Instruction. Wisconsin Guide to Childhood Hearing Screening. *Madison: WDPI, 1993, p. 18.*

Hearing Screening Referral/Medical Evaluation

Date

Referring Program Street Address

Referring Program Address *City, State, Zip*	Phone No. *Area Code*
Child's Name	Child's Birthdate *Mo./Day/Yr*

Dear Physician:

The child named above failed the school hearing screening process on ________(date)________ and ________(date)________. When two successive hearing screenings are failed four to six weeks apart, we recommend that children be referred for medical and hearing evaluations.

It is very important that we learn of the results of the medical and hearing evaluations. Therefore, please return this form, with sections A and B completed, to the child's parent or guardian or to the above address as soon as possible. As always, your feedback is greatly appreciated.

A. Physician's Findings and Recommendations

Right	Left		(Describe Findings)
		Otitis Media	
		Otitis Externa	
		Eardrum Abnormality	
		Ear Wax	
		Other Pathology	
		No Pathology	

Recommendations

Physician's Name *Print or Type*	☐ ENT ☐ PED ☐ FP
Physician's Signature	Date Signed

B. Hearing Evaluation Findings (attach audiogram and tympanograms and include auditory management recommendations)

Tester's Name *Print or Type*	Audiologist ☐ Yes ☐ No
Tester's Signature	Date Signed

Source: Wisconsin Department of Public Instruction. Wisconsin Guide to Childhood Hearing Screening. *Madison: WDPI, 1993, p. 19.*

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Program Standards for Children's Vision Screening

Preschool Entry Day Care Entry or Age 3 or 4	history			ophthalmologist optometrist pediatrician family physician primary physician registered nurse
	physical exam of eye	eyelids & orbits	**asymmetry or inability to open eye(s)**	
		penlight evaluation: conjunctiva, sclera, cornea and iris	**asymmetry, enlargement of cornea or globe or corneal haze**	
		red reflex	**reflex is asymmetric contains dark spots, is blunted on one side, absent or shows a white reflex**	
	distance visual acuity	Any one of the following: Snellen letters, numbers or Es HOTV Lea Symbols	**half or less corrrect on 10/20 (20/40) line with either eye tested monocularly**	
	ocular alignment	Random Dot E Sterotest at 40 cm	**less than 4 of 6 correct**	
		or monocular cover test at 3 m (10 feet)	**any eye movement**	
Kindergarten Entry	same as age 3 or 4	see Preschool/Day Care Entry - Age 3 or 4	**see Preschool/Day Care Entry - Age 3 or 4**	ophthalmologist optometrist pediatrician family physician primary physician registered nurse
	color vision *(will be tested in Sun Prairie and Whitewater only)*	APT-5 Color Vision Tester	**diagnoses mild, moderate & severe cases of red-green color defects**	
EACH of following **Grade 3** **Grade 5** **Grade 8** During High School any of the following **Grades 9-12**	history			ophthalmologist optometrist pediatrician family physician primary physician registered nurse
	physical exam of eye	eyelids & orbits	**asymmetry or inability to open eye(s)**	
		penlight evaluation: connunctiva, sclera, cornea and iris	**asymmetry, enlargement of cornea or globe or corneal haze**	
		red reflex	**reflex is asymmetric, contains dark spots, is blunted on one side, absent or shows a white reflex**	
	distance visual acuity	Any one of the following: Snellen letters, numbers or Es HOTV Lea Symbols	**half or less corrrect on 10/15 (20/30) line with either eye tested monocularly**	
	ocular alignment	Random Dot E Sterotest at 40 cm	**less than 4 of 6 correct**	
		or monocular cover test at 3 m (10 feet)	**any eye movement**	
New Students, Parent or Teacher concerns over symptoms	components appropriate to child's grade	components appropriate to child's grade		ophthalmologist optometrist pediatrician family physician primary physician registered nurse

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Snellen Wall Chart Testing Procedures

Snellen Wall Chart. To properly use the Snellen Wall Chart, the screener must first select a quiet test area, free from distractions. This area should be large enough to allow a 20-foot lane with no obstruction between the child and the chart. If it is not possible to obtain this distance, a 10-foot child-to-chart distance can be used with a chart designed specifically for 10 feet. The chart should be properly illuminated for best results. A self-illuminated unit is recommended for distance testing whenever possible. Prevent Blindness-America recommends illumination of 10- to 30-foot candles evenly diffused over the chart. This assures evenly distributed standard illumination.

A short orientation is advisable to acquaint the children with the test materials and to teach them the method of responding. Keep the instructions simple and clear so that they know exactly what is expected of them.

Preschool, kindergarten, and first-grade children should be taught the "E" game. This may be best accomplished in small groups of 4 or 5 children. Use the training "E" to introduce the directional concept. The E symbol is usually interpreted as a table and the children are taught to point with their arms or hands in the same direction that the "table legs" are pointing. The children are ready for screening when they understand the "E" game.

Older children should be taught to identify the letters as the screener points to the letters on the Snellen Wall Chart.

All screening team members should be at their assigned locations.

- Ask the child to stand (with heels on the line) or sit at the 20-foot (or 10-foot) mark facing the chart.
- If the child wears glasses or contact lenses, screen with them in place. (If the child has glasses or contact lenses and is not wearing them, screening should be rescheduled.)
- Begin screening with the line above the critical (referral) line for the child's age (that is, for three year olds, show symbols on the 50-foot line; for those ages four and over, start with the 40-foot line).
- Test each eye separately—right eye first, then left eye. A standardized routine avoids confusion and facilitates consistent recording.
- Test the right eye first according to the following procedure:
    1. Occlude the left eye. Tell the child to keep both eyes open. For young children, the screener may need to hold the occluder, cupping it slightly to avoid touching the eye. A separate occluder should be used for each child and discarded after use.
    2. Ask the child to identify symbols in order, starting with first line and moving across the line from left to right.
    3. To succeed with a line, the child must be able to correctly identify at least one more than half of the symbols on the line.
    4. If the child can identify more than half of the symbols on a line, the screener presents each smaller line of symbols through the 20-foot line. The screener may change direction with each line presented (that is, follow a snake pattern to make it more difficult for the child to memorize the responses). If the child can identify the 20-foot line correctly, record the visual acuity attained as 20/20. (Visual acuity is recorded as a fraction; the numerator represents the distance, and the denominator the line read.)
    5. If the child fails to read a line, repeat the line in reverse order. If the child fails the line twice, record the visual acuity as the next higher line (that is, if the child fails on the 30-foot line, record the acuity as 20/40).
    6. If the child fails twice on the first line of symbols presented, move up the chart to the next larger line of symbols. If the child fails this line, continue up the chart until the child can successfully identify a line of symbols, then return to the line below. Continue moving down the chart until

the child fails twice to identify a line correctly. Some children with low vision may not be able to read the largest 200-foot symbol. Record the vision as "less than 20/200."

7. If the screener is in doubt as to whether a child has passed a line, have the child do the entire line over from the opposite direction.

- Repeat the above procedure with the left eye.
- Record visual acuity (the smallest line read correctly) in the order read (right eye, left eye) on the vision screening roster.
- Record all signs of possible eye problems.
- Children who have failed the screening should be rescreened later that day or on another day to determine if it is a true failure and not related to other factors which may have caused the child to perform poorly.
- Refer all children who fail the rescreening (see recommended referral criteria below).
- Refer all children passing the visual acuity screening using the Snellen Chart for testing with the Random Dot E Stereopsis Tool.

Specifically, the nurse should refer any five-year-old child who:

- does not pass the 10/20 line (20/40 equivalent) of the Snellen Chart or HCTV or Lea Symbols 10/16 (10/32 equivalent) with each eye by correctly identifying more than half of the characters on the line; or
- does not correctly identify the E four out of six attempts with the Random Dot E Stereopsis Tool; or
- shows any of the signs of possible eye problems previously listed in this chapter.

The nurse should also refer any six-year-old child who:

- does not pass the 10/15 line (20/30 equivalent) with each eye by correctly identifying more than half of the characters on that line; or
- does not correctly identify the E four out of six attempts with the Random Dot E Stereopsis Tool; or
- shows any of the signs of possible eye problems previously listed in this chapter.

Source: Prevent Blindness-Wisconsin. Guidelines for Children's Vision Screening. *Milwaukee: PB-W, 1994.*

Random Dot E Stereopsis Screening Procedures

☐ Select a quiet test area, free from distractions.

☐ Explain Random Dot E Stereopsis screening procedure, showing the child the model card. Ask the child to touch the model card to better understand that the picture will stick out or be raised.

☐ Gently place the Stereopsis glasses on the child.

☐ Show the child both the "Stereo Blank" card and the "Raised/Recessed E" card simultaneously. Hold both cards upright, 16 inches from the child at his/her eye level, so that you can read the words "Stereo Blank" and "Raised" on the back side of each card. The cards must be held vertically. Avoid tilting the card toward the floor or ceiling as this will cause darkness and glare.

☐ Ask the child to look at both cards and point to the card with the "E."

☐ The "E" must be presented randomly up to six times. Using the following order, present the "E" card to the child holding the "E" card to the left, below, right, above, and then to the left of the blank card.

☐ To pass the Stereopsis test, the child must correctly identify, four out of six times, the card that has the raised "E."

☐ Children who fail the Stereopsis screening should be rescreened later that day or on another day to determine if the failure is a true failure and not related to other factors which may have caused the child to perform poorly.

☐ Record the results of the Stereopsis screening.

☐ Refer all children who fail the Stereopsis screening.

Source: Prevent Blindness-Wisconsin. Guidelines for Children's Vision Screening. *Milwaukee: PB-W, 1994.*

Sample Parent Notification Letter and Vision Screening Referral/Examiner's Report

(School District name, address, telephone number, and contact person)

Date: ___________

Dear Parent:

Your child, ______________________________ participated in a vision screening at school on ______________________. S/he did not perform satisfactorily on the vision screening and subsequent vision screening retest. This was a screening for possible vision problems and not a complete eye examination.

Screening results

☐ Your child was unable to see the line on the chart appropriate for her/his age group.
  ☐ Right eye
  ☐ Left eye
☐ Your child did not pass the depth perception screening.
☐ Other: ____

We recommend that you contact and establish an appointment for your child with an eye care specialist. Please take this letter along with you to the eye care specialist. The form on the back of this page should be completed and returned to your child's school at the address provided above.

Several suggestions to help arrange for your child's eye examination:

- Call your family physician or health-care provider for the name of a qualified eye care specialist.
- Contact local ophthalmology, optometric, or medical societies.
- Call us for the local Lion's Club or other service organization if an eye examination and possible resulting treatment for your child poses financial hardship.

Please feel free to contact me if you have questions about the vision screening program or your child's results.

Sincerely,

____

School Nurse

Source: Prevent Blindness-Wisconsin. Guidelines for Children's Vision Screening. *Milwaukee: PB-W, 1994.*

Examiner's Report

Dear Eye Care Specialist:

Please complete and return this form following your examination of the child named on the reverse. All examination results are confidential and for statistical use only.

Visual Acuity: uncorrected Right 20/ ____ Left 20/ ____
corrected Right 20/ ____ Left 20/ ____

Diagnosis
☐ Normal vision
☐ Amblyopia
☐ Muscle imbalance

History
☐ New case
☐ Previously diagnosed
☐ Other (specify) ____________________

Refractive Error
☐ Myopia
☐ Astigmatism
☐ Hyperopia
☐ Other (specify) ____________________

Treatment
☐ Glasses prescribed
☐ Other (specify) ____________________
Recommended educational adjustments: ____________________

Examiner's Name	Address

Examiner's Signature	Date Signed

Parent Notification Letter for Scoliosis Screening

(School District name, address, telephone number, and contact person)

Date ___________

Dear Parent or Guardian,

The ______(name)______________ School will be conducting Postural and Scoliosis Screening on ______(date)______. The purpose of this screening is to identify early signs of possible spinal problems in children in grades _______. This screening is not diagnostic, however, will identify young people who may need further evaluation and diagnosis.

If your child has any unusual findings, you will be notified with a recommendation to contact your local health care provider for an evaluation. The majority of students exhibit no abnormality. If nothing unusual is found, we will not be contacting you again until scoliosis screening is scheduled next year.

Female students are asked to bring a two-piece swimsuit or halter top and shorts to school to be worn during the screening. This type of clothing permits more accurate observation of the back.

If you have any questions, please contact me at ___(phone number)____.

Sincerely,

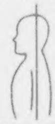
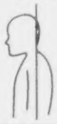
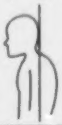
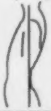
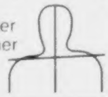
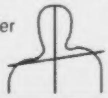
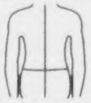
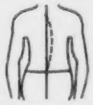
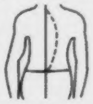
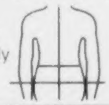
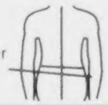
____

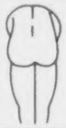
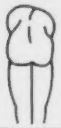
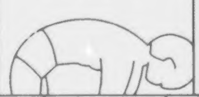
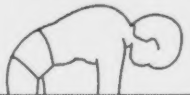
School Nurse

Scoliosis Examination Documentation Chart

*Name*______________________________ *Scoliosis Screening Form*

FINDINGS *N=NORMAL* *M=MODERATE* *S=SEVERE (SHADED)* OUTCOME Recheck ☆ 3-4 wks.

A 6 7 8 9 Upper back normally rounded, neck erect, chin in, head in balance 	6 7 8 9 Upper back slightly more rounded, neck slightly forward, chin slightly out 	**6 7 8 9** **Upper back markedly rounded, neck markedly forward, chin markedly out** 
B 6 7 8 9 Abdomen flat	6 7 8 9 Abdomen protruding	6 7 8 9 Abdomen protruding and sagging
C 6 7 8 9 Lower back normally curved	6 7 8 9 Lower back slightly hollow	**6 7 8 9** **Lower back markedly hollow** 
D 6 7 8 9 Shoulders level horizontally	6 7 8 9 One shoulder slightly higher than other 	**6 7 8 9** **One shoulder markedly higher** 
E 6 7 8 9 Spine straight 	**6 7 8 9** **Spine slightly curved laterally** 	**6 7 8 9** **Spine markedly curved laterally** 
F 6 7 8 9 Hips level horizontally 	6 7 8 9 One hip slightly higher 	**6 7 8 9** **One hip markedly higher**

G  6 7 8 9	 6 7 8 9	6 7 8 9 	**6 7 8 9** 

GRADE	6th	7th	8th	9th
Date Screened				
Date Rescreened				

☐ Noncompliant (referral was made; parent/guardian did not follow up)

NORMAL ☐ (No follow-up nec.) HOLD ☐ (Rescreen 1 yr.)

Under Care ☐ Own M. D. ☐ Specialist ☐ Chiropractor

☐ Wears Brace ☐ Surgery (year______)

COMMENTS

____

REFERRAL INFORMATION:

Student's D. o. B. ______________

Parent/Guardian ______________

Address ______________

____

Home # ______________

Father's Work # ______________

Mother's Work # ______________

Initial Contact (date) ______________

Referral Form sent (date) ______________

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Scoliosis Screening Referral/Examiner's Report

Date ____________

Dear Parent,

Your child ______________________ participated in our school scoliosis screening program. The cause of scoliosis (curvature of the spine) is unknown. It becomes more apparent during adolescence because of the growth spurt. This condition can more often be corrected if found at an early age. The results of this screening indicate that your child needs further evaluation to determine whether or not he/she actually has any curvature of the spine and if it may require treatment. We urge you to take your child to your family physician for further examination.

Please request that the examining physician complete this form. Return the completed form with your signature to the school nurse as soon as the exam has been completed.

Thank you for your cooperation. Please feel free to call me at ____________ if you have any questions.

Sincerely,

Physician's Findings and Recommendations

Name of Patient

☐ Standing (anterior-posterior) x-ray shows:

☐ No Significant findings at this time

☐ Need for further evaluation

☐ Re-examination or treatment recommended *If so, date*

☐ Activity Restrictions:

Additional Comments:

Parent's Signature	Date Signed
Physician's Signature	Date Signed

Appendix PP ■

Common Health Conditions in School-Age Children

Common Health Problems	*Immediate Treatment*	*Comments*
Asthma—Acute Episodes Trouble with air exchange, usually accompanied by audible wheezing	• Use peak expiratory flow meter if available • Administer inhaler, as directed • Follow child's IHP, if available • Rest and provide fluids	• Develop IHP if ongoing health-care needs exist • Physical education: use inhaler before exercise • Be aware of and avoid what triggers attacks • Asthma cannot be used to exclude students from physical education or athletic teams unless indicated by the primary health-care provider
Ear Pain Pain in ear, pulling or rubbing ear, fever, cold symptoms; possible drainage from ear	• Measure temperature and provide area to rest • Contact parent/guardian • Refer to primary-care provider	• Be alert to change in child's hearing; frequent ear infections can result in hearing loss • Refer for audiology testing if loss is suspected
Fractures and Dislocations Pain, swelling, discoloration of affected area; instability or inability to bear weight; may have obvious deformity at site of fracture	• Elevate injured area • Immobilize and prevent weight bearing • Apply ice or cold pack to the injured area • Notify parent/guardian	• Follow school district policy for transport to local emergency room or medical clinic • Requires x-ray to diagnose • Follow-up for environmental modifications
Gastroenteritis—stomach flu Nausea, vomiting, diarrhea, abdominal pain	• Notify parents/guardian if child has severe pain, fever, and frequent diarrhea and vomiting • Provide child with emesis pan and access to a bathroom • Provide area to rest	• Usually viral and mild in nature • Usually spread by oral-fecal route • Younger children and children with developmental delays are at greater risk of spread to others due to poor hygiene habits
Headaches Pain, occasional sensitivity to light, nausea	• Clarify location of pain, frequency, what makes it better, what makes it worse • Rest in quiet place • Administer analgesia as authorized by physician and/or parent	• Refer for medical treatment if pain continues in combination with neurological signs (visual disturbance, weakness in extremities, or speech problems)

Common Health Problems	*Immediate Treatment*	*Comments*
Head Injury Pain, evidence of bruising or abrasions, bleeding; nausea and vomiting; confusion or loss of consciousness	• Obtain history of how accident occurred. • Ask child his/her name, where s/he is, and what time it is—**be alert to disorientation or any change in memory** • Be aware of any potential injury to the child's neck (for example, an injury sustained during participation in a contact sport) • Check coordination, presence of dizziness, headache, vomiting, drainage from any orifice • Pupils of eyes should be equal, round, react to light and accommodation • If injury is mild, have child rest and observe	• Transport immediately to emergency facility if student is unconscious, has change in level of consciousness, bleeding from ear, complaints of visual disturbance, or severe pain • Notify parent/guardian; recommend the child see primary-care provider if there are signs of progression or moderate-to-severe injury
Menstrual Disorders Abdominal cramping and pain, irritability	• Rest in a quiet area • Administer analgesia as authorized by parent	• Refer to physician if a frequent problem that interferes with school attendance and performance
Vague Pain Can occur anywhere, most frequently abdominal pain or headache	• Evaluate location (have child point to area), severity, length of episode • If stomach ache, ask when last ate, if hungry, and so forth • Have rest and observe	• If frequent complaint with no apparent cause, confer with family to see if medical evaluation is needed
Non-Contagious Skin Disorders—Contact Dermatitis Redness, rash, severe itching, localized in area	• May be hypersensitivity reaction of the skin to contact with an allergen • Try to identify the allergen and remove • Contact parent/guardian for medical evaluation • Prevent itching and scratching	• Child will not need to be excluded • Assess environment to eliminate the allergen
Sore Throat	• Measure temperature • Inspect throat • Contact family for medical evaluation	• Strep throat **cannot** be diagnosed by sight alone; throat cultures must be done • If strep, exclusion—may readmit after 24 hours of antibiotic therapy *and* if no fever for preceding 24 hours • All antibiotics must be taken; untreated complications may include serious kidney, cardiac, or musculoskeletal manifestations

Common Health Problems	*Immediate Treatment*	*Comments*
Sprains and Strains Pain, rapid swelling, discoloration at affected site; generalized pain on movement	• Elevate extremity • Immobilize area and prevent weight bearing on lower extremities • Apply ice or cold pack to area	• Notify parent/guardian • Child may need evaluation by primary-care provider • Environmental modifications may be needed
Upper Respiratory Infection—Head Cold Mild fever, runny nose, sore throat, mild cough	• Measure temperature • Call family if fever, ear pain, purulent nasal discharge, deep cough • Careful handwashing and handling/disposal of tissues	• Children have an average of 3-8 upper respiratory infections a year • No exclusion unless fever or cannot function in the classroom
Urinary Tract Infection Fever, pain on urination, frequent urination, abdominal or flank pain, perineal itching	• Measure temperature • Call family for medical evaluation • Rest, provide ready access to a bathroom	• More common in young girls than boys • Child needs to be allowed to go to bathroom whenever necessary • Adequate fluid intake • Reccurrence is common

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Common Chronic Health Conditions in School-Age Children

Health Condition	Consideration for Schools	Comments
Acquired Immune Deficiency Syndrome (AIDS)	• **Use universal precautions for ALL children** • Exclude from school if weeping skin lesions or skin eruptions cannot be covered • Increased susceptibility to infection; inform child's family of communicable diseases present in school • Depression/fear may occur - provide support systems • Address fears and concerns of other students and their families if HIV status is known to students and their families	• Inservice school personnel and educate students regarding HIV/AIDS risk behaviors, transmission, testing, treatment, and prevention • May need to modify schedule based on activity intolerance and immune functioning • School nurse documents an IHP, meetings, training sessions • All records related to HIV status are to be kept in confidential file • May not notify others of presence of child with HIV/AIDS without parental permission
Allergies (severe)	• Make all school personnel who have contact with child aware of the allergy • Have injectable epinephrine readily available for use, if necessary	• Have emergency plan for treatment of anaphylactic (severe allergic) reaction • After treatment at school, child should be seen for medical evaluation
Arthritis, Juvenile Rheumatoid	• May require dependence on others • Illness may be accompanied by rash, fever, systemic involvement • Frequent absences affect academic performance	• May require activity restrictions and schedule modifications during symptomatic periods • Possible modifications in transportation needs
Attention Deficit Disorder (ADD)	• Must receive medications as prescribed at school • Document child's response to medication and program plan, particularly any side effects • Ongoing communication with parents, and physician • Possible incompletion of assignments • Poor socialization skills	• May require modifications in schedule and behavior modification • Develop an IHP to address medication regime, behavior management, classroom structure, and socialization skills

Health Condition	Consideration for Schools	Comments
Asthma (nonacute)	• Asthma which is well-managed cannot be used to exclude a student from physical education or athletics • Notify family of excessive inhaler use • Self-medication under supervision • Medication before physical activity will help prevent exercise induced asthma	• Adaptation of activities that trigger exacerbations, documentation of them, and communication with parents and school personnel on an ongoing basis • Incorporate known triggers, symptoms specific to that child, medications; plan to manage shortness of breath, coughing, and wheezing episodes into IHP
Cerebral Palsy	• May tire easily, muscles ineffective or inefficient • Impaired fine and gross motor skills • Swallowing may be impaired • Frequent speech and language deficits • Cognitive deficits often require disability services	• Collaboration with parents, school personnel, and related services to develop IHP that meets student's needs • Address self-care activities in IHP • May require orthopedic devices to assist mobility • Assess for safety issues when developing IHP
Chronic Fatigue	• Must be medically evaluated to rule out psychosocial or other physical causes	• May require shortened academic time periods, shortened assignments, early class dismissal for transitions • Maintain coordination between home, school, and physician regarding the effectiveness of accommodations
Cystic Fibrosis	• Inherited condition; progressive pulmonary involvement and nutritional malabsorption • Many degrees of disability from minimal to marked • May require respiratory treatments and physical therapy during the school day • May require medication before each meal or snack to aid in absorption • Possible delay in onset of puberty • Encourage physical activity, as tolerated • Requires increased fluids to thin mucus secretions	• Develop an IHP to address multiple health issues • Possible modifications to include dietary, rest periods, respiratory treatments, frequent absence • Re-evaluate health status frequently; potential for deteriorating health status and increased need for modification

Health Condition	**Consideration for Schools**	**Comments**
Diabetes	• May affect mood, fatigue, mental sate • Notify family of planned activities that will affect activity level or nutritional plan • Mild insulin reactions may be manifested by behavior problems, weakness, and hunger • Potentially life-threatening if low blood sugar • Teach and encourage self-care of diabetic regime	• Train staff in diabetic management and coordinate accommodations needed with family, child's physician, and school • Incorporate child's specific signs of blood sugar reaction and specific treatment into IHP • IHP may include related services (activity, transportation, medication administration, dietary needs) • Accommodations may exclude extracurricular activities, field trips, physical education, lunch and/or other scheduling issues
Down's Syndrome	• Varying degrees of mental and physical involvement • Possible medications for congenital heart defects • Associated physical problems: hearing loss, cataracts, leukemia, heart defects • Physical examination to include assessment of cervical spine if going to participate in athletics • Possible early onset of puberty	• May require disability programming and modifications based on cognitive level, hearing or vision impairment • Potential activity restrictions if there is heart involvement
Hemophilia	• Communicate safety concerns to school staff • Blow to head or abdomen should have medical evaluation for internal bleeding. • Resume activities slowly after bleeding episode	• Develop IHP for management of bleeding episodes and first aid practices • May require modification in activity and provision of safe environment
Immunosuppression (non-AIDS)	• Notify parents of presence of communicable diseases in the school • Notify parents if child is running a fever • May cause exacerbations in other common childhood illnesses	• Develop IHP to address prevention of exposure to communicable disease • Modifications may be needed for frequent absences
Scoliosis	• Moderate to severe curves will affect heart and lungs • Treatment regime may cause discomfort and affect self-esteem	• Potential modifications in physical activity

Health Condition	Consideration for Schools	Comments
Seizure Disorder	• All staff working with student must be knowledgeable of student's condition, first aid practices, and emergency plan • Protect student from injury during seizure episodes • Communicate to parents any seizure pattern, frequency, duration • Assess effectiveness of treatment/medication • **DO NOT** put objects in student's mouth or try to force mouth open	• School nurse to train staff and students in seizure management and first aid • Document seizure episodes, including pattern, duration, frequency, first aid, and treatment • Develop IHP to address seizure pattern, type, treatment, emergency plan, when to call for emergency transport
Sensory Deficits	• May affect speech, language, and/or developmental level • Assess impact on socialization and self-care skills • Improper interventions may be masked by behavioral problems • Early detection gives optimal prognosis	• May require equipment to improve level of loss • Collaborate with school and family to identify appropriate accommodations and address in IHP
Sickle Cell Anemia	• Activity may be reduced temporarily after a crisis event • Neurological symptoms may indicate cerebral insult • Requires effective pain management • Attendance affected by episodic flare-ups	• Develop IHP that reflects signs of sickle cell crisis which are specific for that child (joint pain is a frequent first sign)
Spina Bifida	• Extent of disorder depends on level of spinal lesion • Potential bowel/bladder, neurological, or orthopedic dysfunctions may require health procedures at school • Loss of sensation puts student at risk for skin breakdown, abrasions, and burns • If student has hydrocephalus, may have a drainage shunt from head to abdomen; **headache, change in behavior, fever, or vomiting need to be evaluated immediately** (may indicate a malfunctioning shunt)	• **Potential Latex Allergy—life threatening** • If latex allergy, remove all sources of latex from the child's environment; IHP to include emergency plan for anaphylaxis • Develop IHP to include accommodations for affected systems and address environmental and physical modifications • If shunted, address signs of increased intracranial pressure

Health Condition	Consideration for Schools	Comments
Technology Dependent Students (tracheostomy, gastrostomy button/tube, and so forth)	• Requires expertise of school nurse to assess specific health needs in school and develop IHP to address them (see Chapter 10) • Monitor assistive devices and equipment	• Incorporate IHP into IEP (see Chapter 10) • Accommodations must be made to ensure access to school • Notify local EMS of the child's presence in school and have emergency plan available for them

Appendix RR

The Physician Consultant: School District Medical Advisor Agreement

In the past, a vague and informal "hand shake" was all that was necessary for a school district to secure the consultative services of a local physician. This is no longer the case, nor should it be. For many reasons, virtually all aspects of providing health services in the school setting have become more complex and exacting than ever before. This change has significantly affected the job of the physician consultant and the relationship that the consultant has with the leadership of the school district.

Strictly speaking, Wisconsin school districts need only involve a physician medical advisor in the formulation of emergency medical response protocols (see Standard (g)). However, a school district will likely wish to avail itself fully of the expertise of its medical advisor in addressing the medical issues with which it must deal. Questions then arise concerning hours of service (both how many and when provided); expected duties, work facilities, personnel, and compensation, among other things. As with any other business arrangement, the terms of the physician's working relationship with the school district are best set forth in a written memorandum of understanding (MoU) or contract.

Elements

The elements of the MoU or contract are those major items which define the working relationship of the physician and the school district. The MoU or contract must address each of these, although the specifics will vary considerably from case to case.

Duties

A physician consultant's duties may be advisory, may involve direct patient care, or may even extend to advocacy and mediation.

Examples of *advisory duties* include:

- Development of emergency care policy and procedure guidelines, including recommendations concerning staffing and training
- Consultation in the prevention, identification, and control of infestations and infectious/contagious diseases
- Consultation on issues related to the school environment and physical plant
- Interpretation of medical records as may be necessary to determine appropriate educational placement and services
- Participation in evaluation and planning meetings as may be necessary for students with significant medical problems
- Participation in the development and execution of the school district's health education program
- Development/revision of district health-care record-keeping and documentation procedures
- Development of sports medicine policies and procedures
- Establishment of a school-based or school-linked health system

Examples of *direct patient care* include:

- Evaluation of students with significant chronic or acute medical problems, possibly including emergency care
- Evaluation of students to assist in the determination of need for an individualized education plan or other special education services
- Identification of students, faculty, or staff with health problems requiring medical referral
- Consultation in monitoring the efficacy and possible side effects of an in-school treatment program
- Provision and/or supervision of medical care at athletic practices and events
- Provision and/or supervision of medical care in a school-based or school-linked setting

Examples of *advocacy and mediation duties* include:

- Assurance of excellent communication between the school district and local primary-care physicians and clinics both in matters concerning individual students and in the general operation of the district's health service
- Facilitation of establishment of appropriate IEP's by acting as an advocate within the school system for students with special needs, and as a liaison between the school district and the student, family, and primary-care physician
- Serving as an expert medical witness on the school district's behalf, if it is deemed appropriate to do so

Time Commitment

The time required of the school district medical advisor obviously will vary with the scope of duties undertaken. It is up to both parties—the physician and the school district—to be candid and realistic about their expectations in this regard. Centering the discussion on the actual needs of the district is a better approach than to simply say, "The district would like a medical advisor for two hours a month," or, "I can't give more than two hours a month to this school job." It gives the physician a better picture of what the job actually entails and will also enable the physician and district to consider other means by which the needs of the district can be met.

Equipment, Physical Plant, Staffing, Extra Services, and Reimbursement of Expenses

The physician and the school district should have a clear MoU or contractual understanding of what each is expected to provide in terms of the above items. The physician may be expected to interact with many people within the school district, but the district should provide, in addition, a specific contact person for the physician. An agreed-on policy regarding reimbursement of expenses should also be part of a contract, if applicable.

Compensation

It is entirely reasonable for the medical advisor to be paid for services provided the school district. Both the amount and the manner of compensation will vary according to the medical advisor's specific duties. It may be a yearly salary; fee-for-service; or according to hourly, weekly, or monthly rates.

Legal Issues

The physician medical advisor and the district should have a clear understanding regarding such things as malpractice coverage, communication with the school district, the physician as an independent contractor vs. employee of the district, ownership of medical records generated within the school system, and contract termination.

Conclusion

From the physician's standpoint, success as a school district medical advisor depends on the same qualities as a successful practice: ability, accountability, affability, affordability, and availability. A well thought-out MoU or contract can ensure a sound business relationship between the physician and the school district and, as a result, improve student health care.

PI 8.01 School district standards.

(2) School district standards.

(g) Emergency nursing services. Each school district board shall provide emergency nursing services under a written policy adopted and implemented by the school district board which meets all of the following requirements.

1. The emergency nursing policies shall be developed by a professional nurse or nurses registered in Wisconsin in cooperation with other school district personnel and representatives from community health agencies and services as may be designated by the board.
2. Policies for emergency nursing services shall include protocols for dealing with pupil accidental injury, illness and administration of medication at all school sponsored activities including but not limited to curricular, cocurricular and extracurricular activities and a method to record each incident of service provided.
3. Arrangements shall be made with a licensed physician to serve as medical advisor for the emergency nursing service.
4. The emergency nursing services shall be available during the regular school day and during all school sponsored activities of pupils.
5. Pupil emergency information cards, equipment, supplies and space for the emergency nursing services shall be appropriate and readily accessible.
6. A review and evaluation by the school board shall be made of the emergency nursing services program at least annually.

Appendix SS ■

Program Development Inventory

Students with Special Health Care Needs

	In Process, Who's Responsible	Implementation Date	Completion Date
1. Establish a *School Health Advisory Committee*			
2. Appoint *advisory committee members* to oversee district services: meet community needs; family centered			
3. Develop *mission statement* to guide district actions.			
4. Have approved *policies* for special health-care programs			
5. Written *procedures* for:			
a. referral, evaluation, placement processes			
b. care planning			
c. delegation of care			
d. IHP and coordination with IEP			
e. equipment maintenance			
f. specific health conditions			
g. home bound			
h. community agency contracts			
6. Method for *documentation*:			
a. student health records			
b. district forms			

Source: adapted from Collins, J., ed. Providing Health Services for Students with Special Health Care Needs *Oshkosh, WI: Cooperative Educational Service Agency No. 6, 1992.*

	In Process, Who's Responsible	Implementation Date	Completion Date
7. Personnel: Documented with job description			
a. medical advisor			
b. professional nurse			
c. assistive and/or paraprofessional			
8. Plan for *training*:			
a. staff development			
b. individual, student specific			
9. Current *resources* listing:			
a. community health and human service agencies			
b. funding			

Appendix TT

Do Not Resuscitate Orders

The issue concerning whether school districts should honor a family's request for a "Do Not Resuscitate" (DNR) response to a student's emergency condition is complex and difficult. Once seen only in the confines of hospitals and long-term care facilities, the issue for school districts requires them to address factors of medicine, ethics, and practicality.

Background

A review of the history of cardiopulmonary resuscitation (CPR) may help in understanding DNR orders in general. Between the years of 1966 and 1973, evidence demonstrated the effectiveness of CPR in maintaining life until other emergency measures could be initiated (Moskop, 1995). In 1973, the Second National Conference on CPR and Emergency Cardiac Care recommended a "broad national program of life support measures," extending CPR capability to the general public (*JAMA*, 1974). Formal training and certification for lay people, professionals, and institutions was initiated soon after.

The inclusion of nonmedical community members in training programs has led to the expectation that trained lay people will attempt CPR when an emergency arises. In fact, CPR is the only medical treatment that can be performed without a medical order. Further, in medical settings, a medical order is required to withhold CPR (Youngner, 1992), setting it apart from other medical procedures.

A 1976 *New England Journal of Medicine* article titled "Orders Not To Resuscitate" recommended that hospitals establish policies for considering and implementing DNR orders, thus formally raising the issue that CPR and other resuscitative measures may not be appropriate for all patients (Rabkin, Gillerman, and Rice, 1976). Since that time, guidelines for implementing DNR procedures in medical settings have been established by the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research and by the Joint Commission on Accreditation of Hospitals (President's Commission, 1983; Moskop, 1995).

Issues

School administrators are understandably concerned about the implications of DNR orders in schools. Schools have an implicit responsibility for ensuring the safety of all students. Safety, in its most basic definition, means to sustain life and well-being. The withholding of a potentially life-sustaining treatment seems contrary to that end. Yet, the well-being of the student in question might better be served by the DNR order (Rushton, Will, and Murray, 1994).

Essentially, district administrators have two separate questions to consider when presented with a request for a DNR response: (1) whether the request is appropriate and (2) how to implement the request. District personnel may be willing to honor the request but may also find that practical considerations are too unwieldy to make it possible.

Appropriateness

The question of the appropriateness of a DNR order for a minor is complex. In most cases, the parents and attending physicians have evaluated the decision at length. It does not come easily to anyone and is usually the culmination of a long process of difficult treatments, hospitalizations, and pain. At the heart of many DNR decisions is the belief by those most closely involved with the child that resuscitation would cause additional harm and pain. In addition, it may be that attempts to resuscitate the child will not be successful (Youngner, 1992).

In essence, physicians and family members are attempting to control the circumstances surrounding a child's death, recognizing that they cannot change the fact that death may soonl occur. When families are faced with the knowledge that attempts to cure or maintain a child are no longer effective, they are often given the option of doing everything possible to ensure comfort. With the help of health professionals, they can provide support, comfort, and reassurance for the child at home and in familiar surroundings throughout the dying process.

Families and physicians may agree that resuscitative efforts would result in pain, noise, separation from family members, and fear. While these are entirely acceptable experiences for anyone who suffers an acute illness or trauma *and* has reasonable hope of surviving, it may not be the best option for terminally ill patients. For a terminally ill child, the strong likelihood is that death will occur anyway in an emergency room or intensive care unit, separated from parents (Youngner, 1992). Therefore, some families choose DNR status for their children.

Why would parents choose to send a terminally ill child to school? Many times children are surprisingly functional even if they have a fatal disease. They may be able to play, go out, and spend time with friends. Even children in hospice programs have been known to live for several years. Depending on their age and strength, they may be keenly interested in remaining in school, participating in studies and activities, and enjoying time with their friends. Many families do not wish to deprive their children of these experiences during the time remaining.

Practical Issues

The National Education Association developed guidelines for implementing DNR orders in schools in the event that districts decide to honor such orders (NEA, 1994). Included in its recommendations were conditions that orders be submitted in writing by the student's physician, that the school district develop a team to consider the request and develop an emergency plan, and that staff and students receive training and counseling (see NEA policy at the end of this appendix).

Forming a committee of school district representatives and community professionals might help determine the appropriateness of a DNR order for students. School officials should not feel the need to make such a decision based simply on what families tell them. The process should involve in-depth conferences not only with the family, but also with involved health-care professionals. Other consultants might include representatives from a local hospital's ethics board, community pediatricians, local public health officials, or local clergy. In addition, a conference with the county coroner's office might be helpful in discussing issues of a child's death outside of the hospital or home setting and the potential local response to such an event.

Implementing a DNR order requires careful planning. Once the decision has been made that the district will consider honoring the request, practical implications should be carefully evaluated. This may take some time (as much as several weeks), but contingencies must be examined before any attempt to implement DNR status is undertaken.

Medical professionals, especially the involved school nurse, need to carefully consider how school personnel should respond to a variety of contingencies. Essential to this process is the identification of possible medical emergencies which may arise for the student (Rushton, Will, and Murray, 1994). Points of discussion include the possibility of an emergency that is unrelated to the disease process itself (for example, a playground injury or choking incident in the cafeteria). School personnel should be very clear about their expected responses to these types of events. A narrowly defined DNR order that states "do not activate 911" may present significant ethical concerns for school staff in the event of accidental injury. In addition, there may be medical interventions that could be administered to assist in providing comfort, yet are not considered resuscitative. These include the administration of oxygen, pain medication, or anti-seizure medication. Specific steps to take in the event of any medical emergency should be clearly outlined; a DNR order does not necessarily mean that nothing will be done for the child. Plans must include providing comfort, reassurance, privacy, and rapid reunion with family members (Youngner, 1992).

All staff members directly involved with the student should expect thorough and on-going training and support in providing treatments and responses to students in an emergency. The school nurse must provide training and supervision for delegated procedures. Clearly, the nurse must also be comfortable in providing supportive care and should seek appropriate information and training before attempting to instruct others.

School personnel who work with a terminally ill student should be prepared to examine their own philosophies regarding end-of-life decisions. Support and guidance can be sought from within the district as well as from community resources such as clergy and local hospice programs. Such consultation is important for care providers and may benefit the student as well, particularly if staff members become more comfortable and confident in providing such care. Of course, the privacy of the student and the family should always be carefully maintained in such discussions.

After initial in-depth discussions and planning, re-evaluation should become a routine component of the care plan and should include close collaboration among the physician, family, school nurse, and school staff. (The Kettle Moraine School District's DNR protocols at the end of this appendix list some questions that need to be answered relative to implementing a DNR plan at a school.)

Student and Staff Issues

When planning DNR implementation for a student, district personnel are obliged to consider other students' and staff members' needs as well. The school nurse, guidance counselor, and/or psychologist should be involved in assisting classroom teachers and students before, during, and after a student's death. Taking cues from the student's family (and from the student prior to death), they should provide opportunities for questions and discussion, as appropriate.

While it is difficult to consider the possibility of a child's death, school administrators would benefit from proactive discussions about district policy regarding requests for DNR status. Many districts are adopting a policy of considering requests on a case-by-case basis rather than a blanket stance. This allows the district to consider the individual needs of students, families, and staff members.

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National Education Association Policy on Do Not Resuscitate Orders

(Adopted by the NEA Executive Committee, June 1994)

Advances in medical technology now make it possible for some severely ill students to attend school and participate in the learning environment. However, there exists an ever-present threat that such students may go into cardiac/respiratory arrest while in school. In some instances, parents of such students, in conjunction with their physicians, have determined that certain emergency procedures such as cardiac pulmonary resuscitation would be too invasive and painful, might cause severe brain damage, or might otherwise result in worsening the student's physical problems. In such a case, the physician will issue a "do not resuscitate" ("DNR") order, directing that no life-saving procedures be utilized.

While DNR orders have been common phenomena in hospitals and nursing homes, they have only recently surfaced in several school districts around the country. This has prompted a number of inquiries and requests for guidance from NEA members and affiliates.

Of particular concern is the question whether a classroom teacher or other school employee must obey a directive from the school employer to comply with a DNR order. As a general rule, a school employee always should obey a specific directive from the employer. Since this is a developing area of the law, however, NEA members should consult with counsel at the state level to determine whether any special state laws or policies address this situation.

While many districts honor requests to follow DNR orders, others have refused, and still others require parents to obtain a court order before honoring DNR orders. The Maryland Attorney General, for example, has taken the position that school officials in Maryland must comply with DNR orders, while the Iowa Attorney General has said that a school "has no duty to comply with a decision by parents and the physician to withhold life-sustaining procedures" because a school is not a licensed health care provider under state law.

The proposed policy does not take a position on whether school districts should, as a matter of public policy, honor DNR orders; that is an issue that should be resolved at the state and/or local level. However, in considering a request to honor a DNR order, the school district should consult with counsel to determine what legal rights and responsibilities it has, including the applicability of a collective bargaining agreement.

While requests to honor DNR orders must be handled on a case-by-case basis, NEA recommends that no request be granted unless the following minimum conditions are met:

1. The parents' or guardians' request is submitted in writing and accompanied by a written DNR order signed by the student's primary licensed physician.
2. The school district establishes a "team" consisting of the parents/guardians, student's physician, school nurse, student's teacher(s), appropriate support staff, and school superintendent or designee to consider the request. The team first considers all available alternatives. If no other option is acceptable to the parents/guardians, then the team develops a "medical emergency plan, "which includes the following essential elements:
   a. The plan specifies what actions the student's teacher or other school employee should take in the event that the student suffers a cardiac arrest or other life-threatening emergency, e.g., telephone the local emergency medical service, apply emergency procedures as determined by the team, contact the parents/guardians, evacuate other students from the classroom, etc.
   b. All school employees who may have supervision of the student during the school day are fully briefed on the procedures to follow in the event of a medical emergency involving the student.
   c. The student wears an ID bracelet while at school indicating that he/she is subject to a DNR order and a medical emergency plan.
   d. The parents execute a contract with the local emergency medical service providing that the service will honor the DNR order; a copy of the contract is made available to the school superintendent/designee.
   e. The team agrees to review the plan and the student's health condition at least on an annual basis.
3. School staff receives the necessary training and counseling, and educational Death and Dying programs are provided for students. In the event the student subject to a DNR order dies, appropriate counseling will be provided to staff and students.

Do Not Resuscitate (DNR) Protocols: Implementation Guidelines for the School Setting

Definition: A "DNR order" is an order written by a physician to suspend the otherwise automatic initiation of cardiopulmonary resuscitation (CPR).

Goal: Working in close collaboration with parents and health care professionals, the district administration–with legal, medical, and nursing consultation–will arrive at a consensual decision in response to a request to honor a DNR order in the school setting. This decision will require an individualized plan of care to be developed that will be:

- In the best interest of the student (child)
- Considerate of and sensitive to parental prerogatives
- Within the parameters of approved medical, legal, and ethical protocol as determined by a district appointed committee
- Workable and appropriate in the educational setting.

Process: A two-fold process is necessary to achieve this goal:

1. A committee of appropriate and competent school and public officials shall consider the legal, medical, and ethical aspects of the DNR request. This committee is responsible for considering all available alternatives and making a determination to honor or to refuse the medical DNR order. District administration will be forthcoming with the student (if appropriate) and the parents regarding the decision. (This committee will be referred to as the "District Appointed Committee"). No single school employee/official shall be allowed to comment and express a view as representing that of the district.
2. A building team (administrator, nurse, psychologist, counselor, and other staff, as deemed appropriate) where the student is in attendance shall be responsible for developing, implementing, and supervising an individualized plan of care for the student within the guidelines established in the district policy addressing medically involved children.

The district superintendent, primary health care physician, parents, and additional professional services (i.e., EMS., district medical advisor) shall be expected to participate throughout this process. Reasonable time must be allowed for this process to occur.

- What staff will be responsible for determining if a situation is an acute emergency necessitating an emergency action response vs. a progression of the disease/condition?
- What will the response be for emergency situations not related to the disease process?
- What specific physical conditions will prevent the student from attending school?
- How will the rights of the dying be met: the right to privacy, dignity, comfort, compassion, companionship?

Family and Medical Involvement

- Does the child have a third-party attendant? Hospice care? How will they be involved?
- How accessible are the parents? How can they be contacted? How quickly can they be expected to arrive?
- How accessible is the medical professional?
- Has a plan been developed with local EMS, i.e., Child Alert 1033? Who will be called and when?
- What are emergency or crisis transport plans? How and under what conditions or circumstances will the student be transported? Parent (designee)? 911—EMS? Private ambulance?

Facilities

- What is the daily transportation plan to and from school?
- What facilities need to be available in the building? Are there special storage needs for equipment or supplies?
- Where can the student be cared for until someone arrives to transport him or her?

Peers

- What will other students be told before and after the student dies? By whom?
- Are there siblings in the building and how are they to be involved?
- What is the post-trauma crisis plan for staff and students?

Additional Considerations

1. It is advisable that the district establish, with an accredited medical facility, a bioethics committee that would work closely with the involved staff and district administration to determine the appropriateness of the DNR order from a medical, legal, and ethical standpoint.
   Considerations would include:
   - Does the state allow for a DNR order to be respected outside a health care facility?
   - Is the student under a DNR order for the home? hospital? other health care facility?
   - Has the county coroner's office been consulted? What is the coroner's position about this circumstance?
   - What will the involvement of EMS be?
   - Was the student involved in the decision-making process and how will the student be mentally and emotionally supported?
2. The consideration of a condition of willingness (such as is found in the state law regarding administration of medications) should be included in any district policy regarding potential DNR situations, i.e., individuals (except a health care professional) employed within that district shall be involved only to the degree they are comfortable and willing to accept such responsibility and have received the appropriate training and support.
3. It is essential to learning that the school be a safe, healthy, intact environment. Consideration must be given to the reality of the impact a student death may have on the whole school community despite the extensive planning and preparation that has taken place. A plan should provide that a student or adult in crisis be transported (evacuated) as soon as possible.
4. Refusal to honor a DNR order does not alleviate the district's responsibility to provide appropriate educational programming and individualized health care planning.

Implementation: If it is the consensual decision of the district-appointed committee to honor the DNR request, the following would need careful consideration in the implementation of the request.

Planning and Setup

- How often will the DNR order be reviewed? By whom?
- How will the plan need to be changed to accommodate deterioration/improvement?
- How will the staff be notified of any changes (cancellation, reactivation, suspension) of the DNR order?

Staff Communication and Involvement

- What level of confidentiality will be observed?
- How will information be communicated to other building staff, parents, community members?
- What staff will be directly involved? How will this staff be trained and supported?
- How will school staff be involved in meeting the physical, emotional, and psychosocial needs of the student?
- What is the post-crisis plan for notifying and supporting staff members?

Student Assessment and Intervention

- What is the availability of the school nurse? What is the expected arrival time if the nurse is not on-site?
- How predictable is the disease process?
- What is the probable course of physical deterioration?
- What exactly will be done for the student?

Source: Reprinted with permission from M. Vose, RN, and J. Deeken, RN, Kettle Moraine School District (revised 3/11/96).

Parent Request for Special Health-Care Procedure

I, the undersigned, who is the parent/guardian of

______________________________ ______________________

(Student name) (Birthdate)

request that the following special health-care procedure ______________________

____

be administered to my child. I understand that a qualified, designated person(s) will be performing the above-mentioned health-care service. It is my understanding that in performing this service, the designated person(s) will be using a procedure which has been approved by me and my child's physician.

____

(Physician's name) (Address) (Phone)

I will notify the school immediately if the health status of ______________________ changes, if I change physicians, or if there is a change or cancellation of the procedure.

I understand that the above procedure should be scheduled before or after school hours, whenever possible. I understand that I am responsible for providing any equipment and supplies.

I understand that the school nurse will provide me with a standardized procedure to review.

Signature of parent/guardian ______________________________

Address: ______________________________

Phone (Home) ______________________ (Work) ______________________

______________________ ______________________

Date ______________________

Source: Adapted from a form developed by Cooperative Educational Service Agency No. 6

Request for Physician's Order for Special Health-Care Services Performed at School

(Name of pupil) (Birthdate)

Dear Dr.

The parent or guardian of the student listed above has requested that a specialized physical health-care procedure be performed at school (see attached). Please complete the "Physician's Order" on the back of this form as soon as possible and return it to the school address given below.

Please notify the school immediately if the order for the procedure(s) changes or if you are no longer treating this pupil. For your convenience, a sample copy of the procedure has been attached for your review.

Thank you for your prompt attention to this matter. Please be advised that the service cannot be provided until your orders have been received.

(Signature of parent) (Date) (Telephone number)

Parent's Authorization for Exchange of Information

To Whom it May Concern:

I hereby give my permission for the exchange of confidential information contained in the record of my child:

(Name) (Birthdate)

between (Name of physician) and (Name of school district)

(Signature of parent/guardian) (Date)

Please return to: (School nurse)

(Name of School)

(Street) (City) (State) (Zip Code)

BEST COPY AVAILABLE

Physician's Order

Name of Student		Birthdate	
Street Address	City	State	Zip

I, the undersigned, as the physician for the above-named student, do recommend and approve the following procedure(s) to be provided to this pupil during school hours:

1. Name and description of procedure(s):

2. The physical condition(s) of this pupil is (are):

3. The procedure(s) is (are) to be provided according to the following time schedule or PRN (as necessary):

4. Please check one item and sign the attached procedure:
   - ☐ I have reviewed and approved the attached procedure as written
   - ☐ I have reviewed and approved the attached procedure with my modifications, which I have noted.
   - ☐ I have attached my recommendations or orders for the procedure.

5. List any specifications for the procedure:

6. Please list any signs or symptoms that may indicate an emergency situation. List the emergency procedures.

7. List any concerns about transporting the student on the school bus.

Physician's Name *Type or Print*		Phone *Area/No.*	
Physician's Signature		Date Signed	
Street Address	City	State	Zip

Source: Adapted from a form developed by Cooperative Educational Service Agency No. 6

Wisconsin School Nursing and Health Service Program Summary
School Year 199x-199x

The purpose of this summary tool is to:

- identify health status indicators and monitor health service needs of students in Wisconsin schools;
- clarify the school nurse's role as a basic and essential school health service provider; and
- provide health information necessary for the school nurse/health service program planners and policy makers at the state and local levels.

School nursing services are defined for this report in six major categories of (1) case finding, (2) nursing care procedures, (3) care coordination, (4) health counseling and instruction, (5) emergency care, and (6) program management. A brief explanation of the six major categories can be found on the accompanying pages.

Demographic Data

Name	Title
School District	County
Total Students Enrolled	Total No. of Schools

School Health Personnel

Indicate the number of registered nurses employed in your school district by the highest level of education attained and their full-time equivalency (FTE) status.

Total No. of RNs	Master's Degree	Nurse Practitioner	Bachelor's Degree	Diploma	Associate Nurse Degree

Indicate the number of individuals and their FTE status in the school district.

LPNs	Health Aide/Clerk	Health Volunteers

Name and Title of School Nurse/Health Service Program Contact Person	Telephone *Area / No.*

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Case Finding

Heath Appraisals/Screening

Indicate the number of students who were screened, number referred, and number of completed referrals.

Screening	No. Screened in Each Grade	No. Referred	No. Referrals Completed
Hearing			
Vision			
Dental			
Development			
Growth (Height/Weight)			
Scoliosis			
Blood Pressure			
Other *Specify*			

No. of Special Education Health Assessments	

Nursing Care Procedures

Chronic Illness/Disabilities

Conditions	No. of Elementary Students	No. of Middle School Students	No. of High School Students	Total No. of Students	No. of Days Lost This School Year
ADD/ADHD					
Life-Threatening Allergies					
Anorexia/Bulimia					
Asthma					
Cerebral Palsy					
Cystic Fibrosis					
Diabetes					
Down's Syndrome					
Epilepsy					
Genetic Diseases					
Heart Disease					
Hemophilia					
Hepatitis B					
HIV/AIDS					

Chronic Illness / Disabilities (cont.)

Conditions	No. of Elementary Students	No. of Middle School Students	No. of High School Students	Total No. of Students	No. of Days Lost This School Year
Malignancies					
Migraine Headaches					
Multiple Sclerosis					
Muscular Dystrophy					
Neuromuscular Disease					
Orthopedic Disability (Permanent					
Psychiatric Disorder					
Renal Disease					
Rheumatoid Arthritis					
Sickle Cell Anemia					
Substance Abuse (Known)					
Other *Specify*					

Chronically Ill / Disabled Children Requiring Specialized Health Care Procedures

Health Care Procedure	No. of Elementary Students	No. of Middle School Students	No. of High School Students
Blood Glucose Monitoring			
Bowel/Bladder Training			
Dressing Change			
Emergency Protocols			
Epi-Pen			
G-tube Feedings			
Health Care Plans			
Injectable Medicines			
Nebulizer Treatments			
Ostomy Care			
Oxygen Administration			
Suctioning			
Tracheostomy Care			
Urinary Catheterizations			
Other *Specify*			

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Medications

Students on	No. of Elementary Students	No. of Middle School Students	No. of High School Students
Long-term Medicine (3 weeks or more)			
Short-term Medicine (less than 3 weeks)			
PRN Medications			

Title of Person Responsible for Medication Procedures	Title of Primary Person(s) Giving Medicine

Services Provided for School Staff

	BP Monitoring	Hepatitis B Vaccine Administration	Tuberculosis Testing	BBP Training	Assessment of BBP Exposure Incidents
No. of					

Care Coordination

	Home Visits by School Nurse	Physicians Contacts	Other Health Care Provider Contacts *Specify*	Parent/Guardian Contacts
No. of				

IEP Involvement *(Check all that apply)*

☐ Formal Notification of IEP Assignment ☐ Member ☐ Provide Information Only

Health Counseling and Instruction

Known Pregnancies

	No. of Elementary Students	No. of Middle School Students	No. of High School Students
Special Education Programs			
Regular Programs			
Homebound			
Dropped Out of School			

Child Abuse (Reported Cases)

	No. of Elementary Students	No. of Middle School Students	No. of High School Students
Child Abuse/Neglect Cases			
Sexual Abuse			

Known Suicide/Homicide Cases

	No. of Elementary Students	No. of Middle School Students	No. of High School Students
Students Attempting Suicide			
Deaths from Suicide			
Suicides Occurring at School			
Deaths from Homicide			
Homicides Occurring at Schools			

Number of Students Counseled/Assisted by School Nurse

	Child Abuse	Nutrition	Nutrition/ Dietary Practices	Physical Activity	Pregnancy	Reproductive Health	Substance Use/Abuse	Suicide
No.								

Number of School Staff Counseled/Assisted by the School Nurse

	Blood Pressure	Illness/Injury	Conference/Consultation About Individual Health Issues/Concerns
No.			

Health Instruction

Does the School Nurse Participate in Development of Health Education Curricula ☐ Yes ☐ No	Teach Health Education Units ☐ Yes ☐ No	Provide Consultation or Resource Materials for Health Instruction ☐ Yes ☐ No

Units Taught *Check all that Apply*

☐ Alcohol and Other Drug Abuse
☐ Mental/Emotional Health
☐ Physical Health
☐ Community/Environmental Health
☐ Nutrition
☐ Other Specify
☐ Human Sexuality
☐ Personal Safety and Emergency Care

Emergency Care

Injuries

	Permanent Disability	Death	Accidents Requiring Law Enforcement Intervention
No. of Injuries at School			

Estimate At-School Minor Injuries Requiring First Aid	Availability of Nurse (Present on School Premises) to Assist Student when Serious Accident Occurred *Check Only One* ☐ All the Time ☐ Most of the Time ☐ Seldom ☐ Never Health

Who is Responsible for First Responder Care and Triage for Serious Injuries *Check all That Apply*

☐ School Nurse ☐ Principal ☐ Health Aide ☐ Secretary ☐ Other *Specify*

Indicate number of schools in the district in which care for students who are sick or injured is provided by a person other than an school nurse

Under the Supervision of a Nurse	Have a Nurse Available on Call

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Injury/Type of Locations

Report only those injuries requiring EMS response or immediate care by a physician or dentist *and* loss of one-half or more days of school.

Type of Injury	Bus No.	Hall	Classroom	Play/ School Ground	PE Class	Shop	Restroom	Lunchroom	Other	Sports/ Extra Curricular Activities
Anaphylaxis										
Back Injury										
Dental Injury										
Eye Injury										
Fracture										
Head Injury										
Heat-Related Emergencies										
Laceration										
Psychiatric Emergencies										
Respiratory Emergencies										
Sprain/Strain										
Other *Specify*										

Program Management

Does the District have a School Health Advisory Council ☐ Yes ☐ No	Titles of Council Members 1. 2. 3.	Are School Records Computerized ☐ Yes ☐ No

School Health Policies

Does your school district have approved policies for: *Check all that apply*

☐ Child Abuse/Neglect
☐ Children with Special Care Needs
☐ Communicable Disease Prevention
☐ Do Not Resuscitate Order
☐ Emergency Nursing Services
☐ Health Appraisals/Screenings

☐ HIV/AIDS
☐ Immunizations
☐ Medication Administration
☐ Student Health Record Management
☐ Other *Specify*

Health Rooms

Number of Schools with Health Rooms	Number of Schools without Health Rooms

Of the schools in the that have health rooms, how many health rooms have the following:

Heat	Water	Telephone	Privacy	Toilet Facilities	Secure Health Record File	Locked Medicine Cabinet	Air Conditioning

Equipment

	Number	Regularly Calibrated *Check if Yes*
Audiometers		☐
Balance Beam Scale		☐
Otoscopes		☐
Sphygmomanometers		☐
Spirometers		☐
Tympanometer		☐
Vision Screening Tools		☐

Salary

Note: Salary information is used to compile state average and range. It is useful for nurses negotiating salary and documenting trends toward more appropriate salary levels for school nurses. This information it not otherwise divulged

Position	Current Average Salary	No. of Days in Contract
Registered Nurse		
Supervisor/Coordinator		
SNP/PNP/FNP		

Are RNs on a salary scale. *If yes, attach a copy.*

☐ Yes ☐ No

School Nursing/Health Services Summary

The information provided will reflect activity during the 199x-9x school year.

The purpose of this summary is to:
- identify health status indicators and monitor health service needs of students in Wisconsin schools;
- clarify the school nurse's role as a basic and essential school health service provider; and
- provide health information necessary for the school nurse/health service program planners and policy makers at the state and local levels.

School nursing services are defined for this report in six major categories: (1) case finding, (2) nursing care procedures, (3) health care coordination,(4) counseling and instruction, (5) emergency care, and (6) program management.

Case Finding

Case finding describes the preventive health assessment and health-screening services that school nurses or others under their supervision provide to students within the school district. It includes nursing assessment and care for students who may have been referred by teachers, other school staff, or a concerned parent; pre-school assessments and periodic health appraisals for Medicaid-insured children who have not received preventive health care; and individual assessments for those students seeking professional advice, anticipatory guidance, and assistance with access to medical care. Health appraisal and screening programs are provided so that health problems which could interfere with a student's ability to learn are detected, referred for diagnosis, and given appropriate treatment, allowing the student to participate fully and achieve to their highest level in school.

Nursing Care Procedures

Because of advances in medical care, more and more students are entering school with complex medical needs. Such children frequently require nursing-care procedures and technical support to participate in school. Nursing services enable schools to serve these students and allow for their optimal level of achievement in school. This category includes those interventions planned for students with chronic or temporary health impairments as defined in an Individual Health Plan (IHP) and documented in the Student Health Record. Services in this category range from the management and administration of medications to the planning and providing of nursing procedures needed to support school attendance. It also includes services provided for school staff, such as blood pressure monitoring, Hepatitis B vaccine administration BBP training, and assessment of exposure incidents.

Health-Care Coordination

School nurses are responsible for managing and coordinating the health care of students who have chronic medical or other health conditions, and they serve as a liaison to parents, physicians, and other community health agencies. They monitor the health status of students and work with school staff as a team member to support students who have special health-care needs. These services are provided so that students with chronic health-care problems are able to participate and optimally achieve in school.

Health Counseling and Instruction

Students often seek a nurse's professional advice about various health concerns. Their concerns range from questions about care of minor health problems to affirmation about normal body changes. Their questions provide opportunities for nurses to promote positive health behaviors, influence decision making,encourage appropriate self-care, and reinforce what students learn in the classroom, making every interaction an educational experience.

Emergency Care

Children are, by their very nature, physically active; where groups of children congregate, injuries can and do occur. Some injuries occurring at school can be serious, defined for the purpose of this report as those requiring EMS response or immediate care from a physician or dentist *and* the loss of one-half or more days of school. Information gathered about injuries and resulting in emergency care is useful in assessing the need for injury-reduction activities within local school districts. Ensuring a safe school environment where learning can take place and disruptions to the school day are minimized is an important role of the school nurse.

Program Management

A primary role of the school nurse is to manage school health services in the educational setting. Program management involves using available resources to address the health needs of school-age children and youth; it requires the planning, organizing, implementing, and evaluating of various programs designed to meet those needs. School districts employ or contract for services of registered nurses for their expertise and knowledge in nursing and community health. Thus, school nurses can provide leadership and take an active role in formulating goals, policies, and procedures relating to school health programs.

Agreement for School Nursing Services

This School Nursing Agreement, dated ____________, by and between Fort Atkinson Memorial Health Services, Home Health Agency, hereinafter referred to as "Home Health" and the School District of ______________________________________, hereinafter referred to as the "District" is to be provided during the next school terms, year round, July 1, _______, through June 30, _______.

WITNESSETH

WHEREAS, the District desires School Nurse Services to provide such services to its students and District staff; and

WHEREAS, Home Health is a nursing service that employs Registered Nurses qualified to practice School Nursing in the State of Wisconsin, hereinafter referred to as "RNs"; and

WHEREAS, Home Health desires to furnish and is qualified to provide those school nursing services;

NOW, THEREFORE, in consideration of the mutual convenants and agreements hereinafter set forth, it is agreed as follows:

1. **Service**
   Home Health shall provide school nursing services to the District those with RNs employed by Home Health as requested by the District.

2. **Qualifications of the RNs**
   Each RN whose services are provided by Home Health hereunder shall:
   a. be qualified to practice nursing in the State of Wisconsin;
   b. be a graduate of an approved baccalaureate program in nursing;
   c. obtain or show proof of continued work toward Department of Public Instruction School Nursing Certification; and
   d. conform to all applicable policies and procedures of the District, providing Home Health is furnished written statements of such policies and procedures.

3. **Duties of the School RNs**
   Each RN whose services are provided by Home Health hereunder shall perform duties including, but not limited to, the following:
   a. oordinate and assist in the training of the Emergency Nursing Services statute (Wis. Stat. 121.02(1)), such as first aid and CPR, and respond to health-related emergencies upon request.
   b. participate in the District's preschool and kindergarten screening programs and preschool census update.
   c. coordinate a process to inform staff of medically involved children in an expeditious manner; facilitate the training of staff working with medically fragile children; coordinate and monitor the administration of medication to students.
   d. develop and implement procedures for the systematic collection of health and developmental data about students consistent with Wisconsin law.
   e. assist in providing direct education services to classrooms, teenage parents, and health-related student assistance programs.

f. serve as a resource to and be a contributing member of the Pupil Services Coordinating Council and Human Growth and Development Advisory Committee serve as a member of special education teams, when assigned; serve as a member of the K-12 Health Curriculum and School Safety Committee.
g. conduct general health screenings across the District.
h. serve as liaison between the District and the medical community.
i. develop and administer the Health Services budget.
j. propose and monitor the implementation of District health-related policies and procedures.
k. perform other duties as directed by the director serving as the Coordinator of School Nursing Services; other duties requested by the Director of Special Education/Pupil Services would be received by the Coordinator and delegated to the school nurses.
l. provide ongoing staff development aroand health-related issues.

4. **Implementation, Supervision, and Evaluation**

School nursing services will be provided by 1-2 RNs, under the supervision of the Director/Manager of Home Health. The School Nursing Services program will be set up in accordance with the National Association of School Nurses recommendations for the Role and Standards of School Nursing Practice. These standards of practice and also the scope of the School Nurse Practice will be reviewed/approved by the Administration of the District and the Home Health Director on an annual basis.

The Director of Home Health, as the coordinator between the Home Health Agency and the District, will be responsible for implementing school nurse practice policies. The coordinator will assist in the collaboration with community health systems, the school system and program management/professional development for RNs functioning in the District.

All documentation, review of student health records, and filing of such documents will be a part of the nurse's responsibility or be delegated to the school health clerk. Referral of students, consultation on behalf of the student with other professionals, and other student/staff health needs will be the responsibility of the School Nurses. Home visitation will be done on an as-needed basis.

Supervision of the School Nurses will be the primary responsibility of the Director of Home Health, in partnership with designated District administrative staff.

Evaluation of the School Nursing Services program will be a join effort done at least annually by the Director of Home Health and designated District administrative staff. Monthly meetings will be set for the purpose of evaluating services provided.Annual evaluation of RNs participating in the School Nursing Services program will be done by the agency per FAMHS policy with input from the District.

5. **Compensation Procedure**

a. Home Health will bill the District a prorated fee, based on an annual fee of $15,034 for the School Nursing Services program. This will be paid to Fort Atkinson Memorial Health Services in twelve (12) monthly increments of $1,253. This equates to $23.49 per hour for wages/benefits. (This is based on a part-time position of 640 hours/40 weeks.) School Nursing Services will be provided with some flexibility during the summer. School nursing services during school breaks will not be provided.
b. Compensation for the school year beginning July 1, 1998, will be compensated forat a 3 percent per year increase from the base of $15,034.

6. **Professional Liability Insurance**

Home Health, as a department of Fort Atkinson Memorial Health Services, shall furnish to the District a valid certificate of insurance evidencing that it has adequate professional liability insurance coverage for the services to be provided hereunder.

7. **Employment Relationship**
The RNs provided under the terms of this Agreement are the employees of Fort Atkinson Memorial Health Services and shall not be considered employees of the District. Fort Atkinson Memorial Health Services shall be responsible for workers compensation insurance coverage, unemployment compensation contributions, and other payroll tax matters as they relate to such RNs.

8. **Modification and Termination**
This Agreement may be modified or amended only by a written agreement executed by the parties hereto. This Agreement shall be effective on the date first above written and until terminated as hereinafter provided. This Agreement may be terminated at any time by Home Health or the District by giving thirty (30) days written notice to the other party.

9. **Notice**
Any notice required or permitted to be given to the parties pursuant to the terms of this agreement shall be in writing and deemed to have been duly given if delivered in person or by mail.

For Home Health

To: Fort Atkinson Memorial Health Services
611 Sherman Avenue East
Fort Atkinson, WI 53538
Attn: John C. Albaugh, President

For the District

To: School District of ___________
(Address)
(Contact - District Administrator)

Policy Topic Areas

Policy Issue Area	Wisconsin Statutes and Administrative Codes	Federal Laws
Curriculum and Instruction		
Health Education	Stats. 115.35; 118.01(2)(d); 118.019; 118.33; 121.02(1)(j)(l); and 121.02(1)(j)(k)(l) Admin. Code PI 8.01(j)(k)(l)	
Human Growth and Development	Stats. 115.35; 118.019; 118.07; and 121.02(1)(j)(k)(l) Admin. Code PI 8.01(j)(k)(l)	
Physical Education		
Protective Behaviors	Stats. 118.33 and 121.02(1)(j)(l) Admin. Code PI 8.01(j)(l)	
	Stat. 1Alcohol and Drug Abuse	
	Child Abuse and Neglect Reporting	
Student Programs		
Guidance and Counseling	Stat. 121.02(1)(e) Admin. Codes PI 4.71 and PI 8.01	
School-Age Parent	Stats. 48.981; 115.91-93; and 118.153 Admin. Code PI 19	
Student Aid	Stat. 115.40 Admin. Code PI 4.71	
Student Assistance	Stats. 115.362; 115.365; 115.40; and 118.24(2)(f) Admin. Code ILHR 32	
Suicide Prevention	Stats. 115.35; 115.365; 118.24(2)(f); and 118.255	
Employee Programs		
Employee Assistance	Stat. 101.055 Admin. Code ILHR 32	
Employee Protection	Stats. 101.055, 118.07, 252.21, and 940 Admin. Codes ILHR 32 and HSS 145	Bloodborne Pathogens Standards
Employee's Right-to-Know	Stats. 101.055 and 101.58	
Employee Wellness	Stats. 101.055; 118.25; and 121.02(1)(b)	
Professional Staff Development	Stats. 121.02(1)(b; 441; N6; and N7 Admin. Codes ILHR 32 and PI 8.01(b)	

Policy Issue Area	Wisconsin Statutes and Administrative Codes	Federal Laws
Child Health and Safety		
Alochol and Druge Abuse	Stats. 115.361-362; 118.126; and 118.24(2)(f) Admin. Code PI 32.03	
Child Abuse and Neglect Reporting	Stats. 48.981; 118.153; 940; and 948	
Communicable Diseases	Stats. 118.15-16; 252.19; and 252.21 Admin. Codes ILHR 32 and HSS 145	Family Education Rights and Privacy Act (FERPA, 1974)
Emergency Nursing Services	Stats. 101.055; 118.07; 118.29; 121.02(1)(g)(i); 441; 448; and 895.48 Admin. Codes PI 3.51 and PI 8.01(g)(i)	
Food Service	Stats. 115.34; 115.341; 115.343; and 115.347	Federal School Nutrition Program
HIV/AIDS	Stats. 115.368; 118.019; 118.125; 118.13; 118.255; 146.81-84; 252.14-15; and 252.21 Admin. Codes ILHR 32; HSS 145; and PI 9	Bloodborne Pathogens Standards ADA (1990)
Medication Administration	Stats. 118.255; 118.29; 146.81-84; 441; and 448; N6; and N7	
Physical Examinations	Stats. 103.15 (staff); 118.25; 118.25(3) (students); and 121.52(3)	Americans with Disabilities Act (ADA, 1990)
Playground Safety	Stats. 118.07 and 121.02(1)(g)(i)	
Relationships with Health Authorities	Stats. 101.055; 118.07; 118.12(16); 120.13(11)(a)(b); 121.02(1)(i); 250.04; 252.04; and 252.21 Admin. Code HSS 145	
Relationships with Social Service Agencies	Stats. 48.981; 115.362; 115.365; 115.368; 118.15; 118.153; and 118.17	
Student Immunizations	Stats. 118.12(16) and 252.04 Admin. Code HSS 144	
Student Safety	Stats. 48.981; 115.362; 115.365; 115.368; 118.07; 118.153; 118.17; 118.24(2)(f); 118.255; 118.29; 121.02(1)(g)(i); and 252.21 Admin. Codes ILHR 32; HSS 145; and PI 8.01(g)(i)	

Child Health and Safety (cont.)

Policy Issue Area	Wisconsin Statutes and Administrative Codes	Student Programs
Students with Special Health-Care Needs	Stats. 115 (sub. V); 115.80; 118.125; 118.13; 118.15(1)(d)(5); 118.16; 118.255; 118.29; 146.81-84; 439.45; 441; 448; N6; and N7 Admin. Code PI 11	Individuals with Disabilities Educa-tion Act, Revised 1997 (IDEA-R97) ADA (1990) FERPA (1974) Section 504 of the Vocational Rehabil-itation Act (1973)
Supervision of Students	Stat. 121.02(1)(i)	
Tobacco Use	Stats. 101.055; 115.362; 115.368, and 121.02(1)(I) Admin. Code PI 8.01(i)	
Safe School Environment		
Accident Prevention, Procedures, and Reporting	Stats. 101.055; 118.07; and 121.02(1)(g)(i) Admin. Code PI 8.01(g)(1)	
Building and Grounds Inspection and Maintenance	Stats. 101.055 and 121.02(1)(I) Admin. Codes ILHR 32 and PI 8.01(i)	Bloodborne Pathogens Standards
Emergency Plans: Bomb Threats, Building Security, Fire Drills, School Closings, Tornado and Weather Alerts	Stats. 101.055, 118.07, and 121.02(1)(g)(i) Admin. Code PI 8.01(g)(i)	
Relationships with Police and Fire Departments and Emergency Government	Stats. 48.981; 118.07; and 121.02(1)(i)(g) Admin. Code PI 8.01(g)(i)	
Safety Programs	Stats. 101.055; 118.07; 118.29; and 121.02(1)(g)(i) Admin. Codes ILHR 32 and PI 8.01(g)(i)	
Student Transportation and Bus Safety	Stats. 118.07 and 121.02(1)(g)(i) Admin. Code PI 8.01(g)(i)	
Weapons in the School	Stats. 948.60-61	
Administrative Areas		
Equal Opportunities	Stat. 118.13 Admin. Code PI 9	ADA (1990)
Personnel Records	Stats. 19 (sub. II); 120.13(2)(e); and 252.15 Admin. Codes ILHR 32 and PI 8.01(2)(q)	ADA (1990) Bloodborne Pathogens Standards
Student Records	Stats. 19.21; 48.981(2m); 51.30; 118.125-126; 146.81-84; 252.11(1m); 252.15; 441; and 767.24 Admin. Code HSS 145.19	FERPA (1974) General Education Provisions Act (1978)

School Policy Development

Step 1: Needs Assessment

- Clarify the need for a new or revised HIV infection-specific policy statement(s) concerning curriculum, health, safety, school environment, and student and personnel records. Gather ideas from school staff members and from policy recommendations available from the Wisconsin Association of School Boards (WASB).
- Review existing policies on health, safety, students with disabilities, employees with chronic diseases, confidentiality, and health education.
- Write a brief description of the issues that need to be addressed.

Step 2: Process Assessment

Critically assess the existing policy development process. Before working on HIV-related policies, it may be necessary to revisit the "foundation policies" that express an educational vision and define policy-making participants, protocols, timelines, and public involvement. For example, rules governing the conduct of speakers at hearings and meeting can help to defuse controversy, but only if they're adopted before the need arises.

Step 3: Procedures

- Use established procedures to bring the policy needs to the attention of the school board.
- Be prepared to suggest who should work to draft or revise a policy. A School Health/Safety Advisory Committee meeting offers a natural forum for considering HIV-related policy ideas. Its backing can help begin to build a broad base of community understanding and support. If such a committee does not exist, an appointed special task force can draft policies.
- To the extent possible, a policy-drafting body should include:
  - Parents, guardians, and/or family members of students.
  - Teachers and administrators.
  - School health staff, student-services personnel, building maintenance staff, food service staff, bus drivers, and other district employees.
  - Middle and high school students, both because the policies directly affect them and they provide a valuable "reality check."
  - Medical advisors knowledgeable about child development and school health issues.
  - Attorneys familiar with federal, state, tribal, and local laws that impact schools.
  - People living with HIV infection, because their experiences are informative.
  - A broad range of community representatives from diverse perspectives, such as clergy, racial and ethnic group leaders, and members of influential organizations. They can help build bridges of respect among constituencies with divergent viewpoints. Participation in give-and-take discussions increases their understanding of the many factors policy makers must balance.
  - Public health and social service agencies, youth service organizations, AIDS service organizations, and other community-based organizations to enhance interagency cooperation and coordination. Consider including representativers of organizations that work with at-risk youth.
  - A representative of the teachers or school employees union, per any collective bargaining agreement.
- Identify a staff professional who could assist the policy-drafting committee with research and writing.
- Draft for the school board's consideration a clear written statement from the committee with a specific action timeline.

Step 4: Research
Assemble information on federal, state, tribal, and local laws and regulations, if appropriate; sample policies from area school districts and the WASB; and information on the most current scientific and medical findings about HIV infection. Call on colleagues, local community experts, and state and national agencies and organizations for assistance and testimony, if needed.

Step 5: Education
Conduct study sessions for both the committee and the school board on the facts relative to their major policy options. It is critical that everyone clearly understands the legal parameters. Arrange for short presentations by credible experts, with ample opportunities for members to pose questions and express their concerns and perspectives. Open meeting laws will require that these sessions be public.

Step 6: Policy Drafting
Draft policy language, drawing on the information gathered and the values and experiences of committee members. Following are some suggested guiding principles:

- Use clear language and accurate terminology, avoiding education, medical, and legal jargon to the extent possible.
- Provide practical guidance to school staff members on how to address specific issues.
- Be consistent with state, district, and school visions for student learning, education reform efforts, and other initiatives.
- Review the draft language repeatedly for consistency with federal, state, tribal, and local laws and regulations.
- Build in accountability, identifying who will be responsible for doing what.
- Include provisions for policy evaluation and periodic review.

Step 7: Public Feedback
Allow time for committee members to share draft policies with their constituents, to seek opinions and reactions, and to report back to the full committee.

Step 8: Final Preparation

- Prepare the final draft for presentation to the school board.
- Begin to develop a proactive communications plan to explain the issues and build support among staff members and the public; prepare a controversy-management plan if indicated.

Step 9: Policy Adoption
Provide requested support as the decision-making body commences policy adoption according to established procedures.

Step 10: Communication
Once adopted, implement the communications plan to inform and educate the community about the new or revised policy. Prepare fact sheets, talking points, and other written materials. Translate the policies into other languages, as needed, so that staff members, the public, and students can easily understand them. Schedule and conduct information sessions for the media and community groups.

Step 11: Implementation
Implement the policies.

Step 12: Evaluation
Follow through with policy evaluation and review procedures.

Source: Adapted with permission from Bogden, J. Someone at School Has AIDS. Alexandria, VA: National Association of State Boards of Education, 1996.

Information Update—Bulletin No. 98.02, January 1998

TO: District Administrators, CESA Administrators, CHCEB Administrators, Directors of Special Education and Pupil Services, and Other Interested Parties

FROM: Juanita S. Pawlisch, Ph.D., Assistant Superintendent
Division for Learning Support: Equity and Advocacy

SUBJECT: Pupil Records of Children with Exceptional Educational Needs

Over the years, the Department of Public Instruction has received many questions about the pupil records of children with exceptional educational needs (EEN). This bulletin addresses some of the most frequently asked questions, including questions about pupil records that must be treated under state law as patient health care records. Attached to this bulletin are two sample notices that may be useful to local educational agencies. One is a "child find" notice, and the other is a notice required under the statutes governing patient health care records. The notices may be adapted and used by local educational agencies to address the notice requirements of the law. The following is a listing of the questions addressed in this bulletin:

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1. ***Where are the requirements relating to pupil records of children with EEN found?***

The requirements relating to pupil records are found in both state and federal law. In state law, the requirements relating to the records of all pupils are located at ‘ 118.125, Wis. Stats. State requirements relating to children with EEN appear at ‘ PI 11.37, Wis. Admin. Code. General requirements relating to school district records other than pupil records are found at ‘ 19.21(6), Wis. Stats. Federal requirements relating to the education records of all pupils are found at 34 CFR Part 99, the regulations implementing the Family Educational Rights and Privacy Act (FERPA) of 1974. Federal requirements relating to education records of children with EEN are found at 34 CFR 300.560-576 of the regulations implementing the Individuals with Disabilities Education Act (IDEA). Also the federal General Education Provisions Act (GEPA) and its regulations contains record retention requirements. The GEPA regulations are found at 34 CFR 76.730-76.734. Information concerning requirements relating to records used to provide services paid for by medical assistance may be obtained by contacting the Medical Assistance Office at the Department of Health and Family Services. See Information Update Bulletin 97.04, *Family Educational Rights and Privacy Act*, August 1997, for information concerning federal confidentiality requirements and the medical assistance program.

2. ***What are pupil records?***

All records directly related to a student and maintained by the school district are pupil records. Pupil records include records maintained in any way including, but not limited to, computer storage media, video and audio tape, film, microfilm, and microfiche. Records maintained for personal use by a teacher and others required to hold a license under ‘ 115.28(7), Wis. Stats., and not available to others, and records available only to persons involved in the psychological treatment of a child are *not* pupil records.

School districts maintain various categories of records, including those categorized as "behavioral records" and others categorized as "progress records." "Behavioral records" means those pupil records which include psychological tests; personality evaluations; records of conversations; any written statement relating specifically to an individual pupil's behavior; tests relating specifically to achievement or measurement of ability; the pupil's physical health records other than immunization records or lead screening records required under ‘ 254.162, Wis. Stats.; law enforcement officers' records obtained under ‘ 48.396(1) or ‘ 938.396(1m), Wis. Stats.; and any other pupil records that are not progress records. "Progress records" means those pupil records which include the pupil's grades; a statement of the courses the pupil has taken; the pupil's attendance record; the pupil's immunization records; any lead screening records required under ‘ 254.162, Wis. Stats.; and the records of the pupil's extracurricular activities.

3. ***May a school district disclose personally identifiable information from pupil records?***
In general, a school district may disclose personally identifiable information from pupil records *only* after obtaining a signed and dated written consent from a parent. The consent must specify the records that may be disclosed; state the purpose of the disclosure; and identify the party to whom the disclosure will be made. The department recommends that the consent state the time period during which disclosure will be permitted. Please note that law enforcement officers' records obtained under '938.396(1m), Wis. Stats., may not be made available unless specifically identified in the written permission. Specific requirements relating to the release of pupil records that must be treated as "patient health care records" are discussed in question 11.

4. ***Are there circumstances when prior written consent of the parent is not required to disclose personally identifiable information from pupil records?***
Yes. A school district may disclose personally identifiable information from pupil records, *except for information from patient health care records*, without obtaining prior written consent under the following circumstances-

- **Progress records** shall be disclosed upon request to the pupil, or the parent or guardian of the minor pupil. Upon request, the pupil, or the parent or guardian of the minor pupil shall be provided with a copy of the progress records.
- **Behavioral records** shall be shown to an adult pupil or the parent or guardian of a minor pupil, in the presence of a person qualified to explain and interpret the records. Upon request, the adult pupil or parent or guardian shall be given a copy of the behavioral records.
- **Progress records** shall be disclosed, upon request, to any Wisconsin or United States judge of a pupil who is the subject of any proceeding in the court. When a disclosure is made pursuant to a court order or subpoena, the district must make a reasonable effort to notify the pupil's parent prior to releasing the records, so that the parent may seek protective action. Parent notification is not required if a district receives a federal grand jury or any other subpoena, and the court has ordered that the existence or contents of the subpoena or the information furnished in response to the subpoena not be disclosed.
- **Attendance records** shall be disclosed to a law enforcement agency, if the law enforcement agency certifies in writing that the pupil is under investigation for allegedly committing a criminal or delinquent act, and that the law enforcement agency will not further disclose the record except as permitted under ' 938.396(1) to (r), Wis. Stats.
- **Notification** shall be given to the county department responsible for supervising a pupil, if school attendance is a condition of the pupil's dispositional order under '' 48.355(2)(b)(7) or 938.355(2)(b)(7), Wis. Stats., within five days of any violation of that condition.
- **Pupil records** shall be disclosed to persons employed by the school district who are required by the department under ' 115.28(7), Wis. Stats, to hold a license and to other school district officials who have been determined by the district to have legitimate educational interests, including safety interests, in the pupil records.
- **Law enforcement officers' records** obtained under ' 939.396(1m), Wis. Stats., shall be disclosed for the purposes of ' 118.127(2), Wis. Stats., to persons employed by the school district who are required by the department under ' 115.28(7), Wis. Stats, to hold a license and other school district officials who have been determined by the school board to have legitimate educational interests, including safety interests, in the those records and to those employees of the school district who have been designated by the school board to receive that information for the purpose of providing treatment programs.
- **Pupil records** shall be provided to a court in response to a subpoena by parties to an action for in camera inspection, to be used only for the purposes of impeachment of any witness who has testified in the action. The court may disclose the records or parts thereof to the parties in the action or their attorneys if said records would be relevant and material to a witness' credibility or competency.

- **Any information required to be maintained under chs. 115 to 121, Wis Stats.,** may be provided to any public officer.
- **Pupil records** that relate to an audit or evaluation of a federal or state supported program that is required to determine compliance with requirements under chs. 115 to 121, Wis. Stats., shall be disclosed to the Department of Public Instruction, upon request. These records shall be kept confidential by the DPI.
- **Immunization records** shall be disclosed to the department of health and family services to carry out any of the purposes of ' 252.04, Wis. Stats.
- **Lead screening records** shall be disclosed to state and local health officials for any of the purposes of "254.11 to 254.178, Wis. Stats.
- **Names of pupils who withdraw from public school prior to graduation** under ' 118.15(1)(c), Wis. Stats shall be provided, upon request, to the technical college district board in which the public school is located, or for verification of eligibility for public assistance under ch. 49 to the department of health and family services, the department of industry, labor and job development, or a county department under " 46.215, 46.22, or 46.23, Wis. Stats.
- **Directory data** may be disclosed to any person after the school has provided the parent, legal guardian or guardian ad litem notice of the categories of information which it has designated as directory data with respect to each pupil and has allowed 14 days for the parent, legal guardian, or guardian ad litem of the pupil to inform the school that all or any part of the directory data may not be released without the prior consent of the parent, legal guardian, or guardian ad litem. See questions 7 and 8.
- **The name and address of each pupil who is expected to graduate from high school** in the current school year shall be provided to a technical college district board, upon request, if the directory data notice has been given and the parent, legal guardian or guardian ad litem has not objected.
- If proper notice has been given, and the parent, legal guardian, or guardian ad litem has not objected, **directory data** that relates to a pupil enrolled in the school district shall be disclosed, upon request, to any representative of a law enforcement agency, as defined in ' 165.83(1)(b), Wis. Stats.; district attorney or corporation counsel; county department under " 46.215, 46.22, or 46.23, Wis. Stats.; or a court of record or municipal court for the purpose of enforcing the pupil's school attendance, investigating alleged criminal or delinquent activity by the pupil, or responding to a health or safety emergency.
- **Personally identifiable information** may be disclosed to the parent or guardian of an adult pupil, without the adult pupil's consent if the adult pupil is a dependent of his or her parents or guardian under the Internal Revenue Code (26 USC 152), unless the adult pupil has informed the school, in writing, that the information may not be disclosed.
- **Pupil records** of a pupil in compliance with a court order under " 48.345(12)(b), 938.34(7d)(b), 938.396(1m)(c), or 939.78(2)(b)(2), Wis. Stats., shall be disclosed after making a reasonable effort to notify the pupil's parent or legal guardian.
- **Pupil records** shall be transferred by a school district to another school or school district upon written notice from the pupil if he or she is an adult or his or her parent or guardian if he or she is a minor that the pupil intends to enroll in the other school or school district, upon written notice from the other school or school district that the pupil has enrolled or upon written notice from a court that the pupil has been placed in a juvenile correctional facility or a secured child caring institution, within five days of the notice. Upon request, the school district must give the parents a copy of the records that were disclosed and an opportunity for a hearing under 34 CFR 99.21.

5. ***May a school district provide information to school staff regarding a student's potential for physically harmful behavior?***

Yes. If the school district determines that there is reasonable cause to believe that a child may engage in behavior at school or under the supervision of school authorities that is physically harmful to another individual, the district may provide information concerning the child's physically harmful behavior to the child's teachers and to any other school official who has a legitimate educational or safety interest in the information. See ß 118.128, Wis. Stats. The information provided must be limited to information reasonably necessary to meet the educational needs of the child and the safety needs of other children and school personnel. A teacher or other school district official may not disclose the information to any other person.

6. ***What records must a school district keep regarding requests for access to and the disclosure of personally identifiable information from pupil records?***
A school district must keep a record of each request for access to and each disclosure of personally identifiable information from pupil records. The record of requests for access and disclosures may be inspected by the parent; the school district official or his or her assistants who are responsible for the custody of the records; and school district, state, and federal officials for the purposes of auditing the record keeping procedures of the district. A record of access by parents and authorized school district personnel is not required, *except that a district must maintain a record of all persons, including parents and school personnel, obtaining access to patient health care records.* The record of requests for access and disclosures must be maintained with the pupil records of the student as long as the pupil records are maintained. The record must include the name of the party, the date access was given, and the purpose for which the party is authorized to use the records. A record of access to patient health care records must also include the time of the release and identification of the specific records released.

7. ***What is "directory data?"***
"Directory data" means pupil records that include the pupil's name, address, telephone listing, date and place of birth, major field of study, participation in officially recognized activities and sports, weight and height of members of athletic teams, dates of attendance, photographs, degrees and awards received, and the name of the school most recently previously attended by the child.

8. ***What steps must a school district take prior to disclosing directory data without parental consent?***
Prior to disclosing directory data, a school district must notify the child's parent, legal guardian, or guardian ad litem of the categories of information designated as directory data with respect to each pupil and allow 14 days for the parent, legal guardian, or guardian ad litem to inform the district that all or any part of the directory data may not be released without prior consent. Usually such notice is given by the district as part of its annual notice to parents of their rights with regard to pupil records. If the parent, legal guardian, or guardian ad litem requests that certain directory data be disclosed only with written consent, then that data may not be released without consent.

9. ***What are "pupil physical health records?"***
"Pupil physical health records" are pupil records that include basic health information about a child. These records are subject to the requirements governing records classified as "behavioral records." Pupil physical health records include immunization records; an emergency medical card; a log of first aid and medicine administered to the pupil; an athletic permit card; a record concerning the pupil's ability to participate in an education program; any lead screening records; the results of any routine screening test, such as for hearing, vision, or scoliosis, and any follow-up to such test; and any other basic health information, as determined by the state superintendent. Such basic health information includes a log of services, such as physical or occupational therapy, provided under the authority of the school district, but does not include records that contain such information as diagnoses, opinions, and judgments concerning the child's health.

10. ***How are records relating to a pupil's health, but not included in the definition of "pupil physical health records" treated?***
Any pupil record that relates to a pupil's physical health and that does not fall within the definition of "pupil physical health records" must be treated as a "patient health care record" in accordance with " 118.125(2m) and 146.81 to 146.84, Wis. Stats. In general, records relating to the health of a child that are authored by a "health care provider," except for records containing only the basic

health information included in the definition of pupil physical health records, are treated as "patient health care records." Section 146.81(1), Wis. Stats., defines "health care provider" to include:

- a nurse licensed under ch. 441;
- a chiropractor licensed under ch. 446;
- a dentist licensed under ch. 447;
- a physician, podiatrist or physical therapist licensed under ch. 448;
- an occupational therapist, occupational therapy assistant, physician assistant or respiratory care practitioner certified under ch. 448;
- until June 30, 1999, a dietitian certified under subch. IV of ch. 448;
- an optometrist licensed under ch. 449;
- a pharmacist licensed under ch. 455;
- an acupuncturist certified under ch. 451;
- a psychologist licensed under ch. 455;
- a social worker, marriage and family therapist or professional counselor certified under ch. 457;
- a speech and language pathologist or audiologist licensed under subch. II of ch. 459 or a speech and language pathologist licensed by the department of public instruction;
- a partnership, corporation or limited liability company of any of the above providers that provides health care services;
- an operational cooperative sickness care plan that provides services through salaried employees;
- a hospice, inpatient health care facility, or a community-based residential facility.

Please note that under ' 118.125(2m), Wis. Stats., any pupil record that contains information other than the basic health information found in pupil physical health records must also be treated as a patient health care record, *regardless of who authored the record.*

The department recommends that health care providers and others should include in their reports or other pupil records information concerning a child's physical health only when such information is related to the child's educational needs. If the report or other record contains only basic health information found in pupil physical health records, then the report or other record will not be treated as a patient health care record. If an evaluation report or other record includes physical health data beyond the basic health information found in pupil physical health records, then the report or other record must be treated as a patient health care record. *The department recommends that patient health care records be maintained separately from other pupil records, because the requirements relating to the release of information from patient health care records are more restrictive than the requirements for other pupil records.*

Any pupil record that contains the results of a test for the presence of HIV (human immunodeficiency virus) antigen or nonantigenic products of HIV or an antibody to HIV must be treated as provided under ' 146.025, Wis. Stats.

11. ***Under what conditions may information from patient health care records be released?***

Access to these records is controlled by the provisions of " 146.82 and 146.83, Wis. Stats. Section 146.82(1) provides that patient health care records must remain confidential. Patient health care records may be released without parental consent only to the persons named at ' 146.82(2). Patient health care records may be released to others only with the informed consent of the child's parent. "Informed consent" means written consent that includes-

- the name of the patient whose record is being disclosed.
- the type of information to be disclosed.
- the types of health care providers making the disclosure.
- the purpose of the disclosure, such as whether the disclosure is for further medical care, for an application for insurance, to obtain payment of an insurance claim, for a disability determination, for a vocational rehabilitation evaluation, for a legal investigation or for other specified purposes.
- the individual, agency or organization to which disclosure may be made.
- the signature of the patient or the person authorized by the patient, and, if signed by a person authorized by the patient, the relationship of that person to the patient or the authority of the person.

- the date on which the consent is signed.
- the time period during which the consent is effective.

After submitting a statement of informed consent, a parent or other person: may access such records at any time during regular business hours after giving reasonable notice; receive a copy of the records upon payment of reasonable costs; and receive a copy of X-ray reports or have the X-rays referred to a health care provider of the parent's choice upon payment of reasonable costs. The health care provider must note the time and date of each request by the parent or person authorized by the parent to inspect the records, the name of the inspecting person, the time and date of inspection, and identify the records released for inspection. *Please note that a parent who has been denied periods of physical placement under " 767.24(4)(b) or 767.325(4), Wis. Stats., does not have the rights of a parent with respect to access to that child's patient health care records.*

12. ***May school district employees access patient health care records without informed consent?***
Patient health care records may be released without informed consent to school district employees or agents if access to the records is necessary to comply with a requirement in federal or state law. Therefore, such records may be released to school district employees and agents who need the information to carry out specific duties relating to the identification, evaluation, placement, and the provision of a free appropriate public education (FAPE) to a child with EEN under state and federal special education laws. Such records may also be released without informed consent to school district employees or agents responsible for the preparation or storage of the records. School district employees obtaining information from patient health care records must keep the information confidential and may not disclose identifying information about the child whose patient health care records are released.

13. ***What is the health care provider's obligation to inform parents about access to patient health care records?***
Each health care provider must provide the parent with a statement paraphrasing the provisions of ' 146.83, Wis. Stats., upon the first provision of services by the health care provider. The department has prepared a statement that may be used for this purpose. [copy attached]

14. ***What records must school districts maintain for a child with EEN?***
Section PI 11.37(2)(e), Wis. Admin. Code, requires school districts to maintain, as part of the pupil records of a child with EEN, parental consents for multidisciplinary team (M-team) evaluation; parental consents for placement in special education; any data used by M-teams to reach decisions, such as evaluation reports; the reports developed by M-teams; individualized education programs (IEPs); placement offers; medical prescriptions required to substantiate any health treatment services provided by the district; medical evaluations, if used to substantiate determination of a disability; and any other records required under subchapter V of chapter 115, Wis. Stats.

15. ***How does a school district protect the confidentiality of information from pupil records of children with EEN?***
Each school district must protect the confidentiality of personally identifiable information from pupil records at the collection, storage, disclosure, and destruction stages. One official at each school district must assume responsibility for ensuring the confidentiality of pupil records. All persons collecting or using information from pupil records must receive training regarding policies and procedures relating to pupil records. Each school district must maintain, for public inspection, a listing of names and positions of employees who may have access to pupil records.

16. ***What are the rights of parents of children with EEN to access pupil records?***
A parent of a child with EEN must, upon request, be shown and provided with a copy of pupil records. Also the parent has a right to have a representative of the parent inspect and review the records. A school district must comply with a request for access to records without unnecessary delay and before any meeting regarding an individualized education program (IEP) or a hearing

under PI 11.10, Wis. Admin. Code. In all cases, the school district must comply with a parent's request within 45 days. A school district may not destroy any pupil records if there is an outstanding request to inspect and review pupil records. If any pupil record includes information on more than one student, the parents of those students have the right to inspect and review only the information relating to their child or to be informed of that specific information.

17. ***Who is considered a parent of a child with EEN?***
A parent means a natural parent; a legal guardian; a person acting as a parent of a child as defined at PI 11.02(37) Wis. Admin. Code; or a surrogate parent who has been appointed in accordance with PI 11.14, Wis. Admin. Code. When a student attains the age of 18, the rights accorded to parents transfer from the parent to the student.

18. ***In a case involving separation or divorce, what are the rights of parents?***
The school district must give full rights with regard to pupil records to either parent, unless there is a court order or other legally binding document relating to divorce, separation, or custody that specifically revokes these rights. The terms of the court order or other legally binding document determine the rights of the parents. A parent who has been denied periods of physical placement with a child by a court in an action relating to divorce or separation does not have the rights of a parent with regard to pupil records.

19. ***Must the school district respond to reasonable requests from parents for explanations of pupil records?***
Yes. The school district must respond to reasonable requests from parents for explanations and interpretations of all pupil records. State law requires that a school district show a parent the child's behavioral records in the presence of a person qualified to explain and interpret the records. *However, a district may not use this provision of the law to unreasonably restrict the parent's right to access behavioral records.*

20. ***May a school district charge parents for copies of pupil records?***
A school district may charge a fee for copies of records, unless the fee would effectively prevent the parent from accessing or obtaining a copy of the records. The school district may not charge a fee to search for or to retrieve pupil records.

21. ***What are the public notice requirements relating to pupil records and EEN?***
At least annually and before any major child-find (screening) activity, each school district must notify parents of their rights with regard to pupil records as part of a special education screening notice. The notice must be given in the native language of the various population groups in the school district and may be given through such means as public announcements, written notices, or paid advertisements. The notice must include-

- a statement of the school district's duty to identify, locate, and evaluate all resident children with EEN, regardless of the severity of their disability.
- the extent to which the notice is given in the native languages of the various population groups in the district.
- a description of the children on whom personally identifiable information is maintained, the type of information sought through child find activities, the methods the school district intends to use to gather the information (including the sources from whom information is gathered), and the uses to be made of the information.
- a summary of the policies and procedures the district follows regarding storage, disclosure to third parties, retention, and destruction of personally identifiable information.
- a description of all of the rights of parents and children regarding pupil records, including their rights under state and federal law, including the Family Educational Rights and Privacy Act (FERPA).
- the educational opportunities available in the community for children with EEN

An example of a notice that may be adapted to meet these requirements is attached to this bulletin.

22. ***If a parent believes the information in pupil records is inaccurate, misleading or violates the privacy or other rights of the child, what action can the parent take?***
If a parent believes the information in pupil records is inaccurate, misleading or violates the privacy or other rights of the child, the parent may request the school district to amend the information. The district must decide within a reasonable period of time whether to amend the information. If the district decides to refuse to amend the information, it must inform the parent of the refusal, and advise the parent of the right to a hearing under the regulations implementing the Family Educational Rights and Privacy Act (FERPA) of 1974. If, as a result of the hearing, the district decides that the information is inaccurate, misleading, or otherwise in violation of the privacy or other rights of the child, it must amend the information accordingly and inform the parent in writing. If the district decides that the information is not inaccurate, misleading or otherwise in violation of the privacy or other rights of the child, it must inform the parent of the right to place in the records a statement commenting on the information or stating the reasons for disagreeing with the district's decision. The parent's statement must be maintained by the district as part of the child's pupil records as long as the contested information is maintained by the district. If the contested information is disclosed to any person, the parent's statement must also be disclosed to that person.

23. ***How long must the school district maintain pupil records?***
Each school district must adopt rules specifying how long pupil records will be maintained. A child's progress records must be maintained for at least five years after the child ceases to be enrolled. A child's behavioral records, including special education records required to be maintained by a school district under ' PI 11.37(2)(e), Wis. Admin. Code, may be maintained for no longer than one year after the child graduates or otherwise ceases to be enrolled, unless the parent or adult student specifies in writing that the records may be maintained for a longer period of time. There are no legal provisions explicitly addressing the period of time patient health care records must be maintained or when they must be destroyed. *The department recommends that a school district include health care providers in developing policies regarding the maintenance and destruction of pupil records that must be treated as patient health care records.*

24. ***How long must a school district maintain special education records?***
Under the record retention requirements of the federal General Education Provisions Act (GEPA), a school district must maintain records to show compliance with the requirements of the Individuals with Disabilities Education Act (IDEA) for at least five years. These records include a child's multidisciplinary team (M-team) reports, individualized education programs (IEPs), and placement offers.

Under the IDEA, a school district must inform the parents of a child with EEN when personally identifiable information is no longer needed to provide educational services to the child. The notice would normally be given at the time the child graduates or otherwise ceases to be enrolled in the school district. The purpose of the notice is to alert parents that certain pupil records may be needed for proof of eligibility for benefits or other purposes. The information that is no longer needed must be destroyed at the request of the parent. Otherwise, under state law the information may be maintained for only one year after the child graduates or otherwise ceases to be enrolled, unless the parent or adult pupil specifies in writing that the records may be maintained for a longer period of time. Therefore, the department recommends that when a child graduates or otherwise ceases to be enrolled, the district obtain the permission of the parent or adult pupil to maintain M-team reports, IEPs, and placement offers for at least five years for audit purposes. If the parent requests destruction of the records or will not grant permission to maintain the records for five years, then the Office of Special Education Program (OSEP), U.S. Department of Education, recommends removing the personal identifiers from the records. Once personal identifiers are removed, the records are not pupil records and may be maintained until they are no longer needed to satisfy the federal record maintenance requirement.

25. ***Is parental consent required for a school district to provide a due process hearing officer with a child's pupil records?***

No prior consent from the parent is required before the child's pupil records are disclosed directly or re-disclosed through a school district's attorney to a due process hearing officer. *However, the disclosure must occur in the course of the school district's presentation of evidence at the due process hearing.*

26. ***May a parent tape record an individualized education program (IEP) meeting?***

The use of tape recorders at IEP meetings is not addressed in state or federal special education law. The decision about whether parents may tape such meetings is left to the discretion of local school districts. Any policy limiting or prohibiting a parent's right to tape record an IEP meeting should provide for exceptions if they are necessary to ensure that the parent is able to understand the proceedings or to implement other parental rights. A policy limiting or prohibiting a parent's right to tape record IEP meetings involves complex issues of federal constitutional law. Interested school districts should consult their attorneys before adopting such a policy. Please note that when a tape recording of an IEP meeting is maintained by the district, it must be treated as a pupil record.

27. ***Do parents have the right to inspect and review test protocols?***

According to the Family Policy Compliance Office (FPCO), U.S. Department of Education, test protocols that do not contain personally identifiable information, such as the child's name, are not pupil records. Therefore, parents would not have the right to inspect and review them. A parent does not have the right to inspect and review documents such as test instruments and interpretive materials that do not contain the student's name. However, a school district would be required to respond to a request to inspect and review, including an explanation or interpretation of, any answer sheet related to a test that the child completed. Please note that when a school district proposes to evaluate a child, the school district must provide parents with a notice that includes a description of the tests or the type of tests or other evaluation procedures the district proposes to use. Further, when the district proposes or refuses to initiate or change the identification, evaluation, educational placement, or the provision of a free appropriate public education (FAPE) to a child, the district must send the parents a notice that includes a description of each evaluation procedure, test, record, or report it uses as a basis for its proposal or refusal.

28. ***When a school district or a facility operated by the Department of Health and Family Services (DHFS) receives an EEN transfer pupil from another school district or DHFS-operated facility in Wisconsin, what is the receiving school district or facility's obligation with regard to pupil records?***

If a school district or DHFS-operated facility, upon receiving an EEN transfer student, does not receive the child's pupil records, then the district or facility must request in writing the child's pupils records from the sending district or facility.

29. ***What is a school district or a state juvenile correctional facility's responsibility to transfer pupil records of a child with EEN who is transferring to another school district, a private school, or a state juvenile correctional facility?***

Within five working days, a school district or state juvenile correctional facility that provides an educational program to its residents must transfer *all* of a child's pupil records to a school district, to a state juvenile correctional facility or to a private school, if the sending district or state juvenile correctional facility:

- receives written notice from the parent that he or she intends to enroll the child in another school district or private school; or
- receives written notice from a school district or private school that the child has enrolled; or
- receives written notice from a court that legal custody of the child has been transferred to the state for placement in a state juvenile correctional facility.

The pupil records *cannot* be withheld for failure to pay fees or fines. Upon request, parents must be provided a copy of the records transferred and an opportunity for a hearing under the regulations implementing the Family Educational Rights and Privacy Act (FERPA). *Please note that school districts must maintain copies of certain records for audit purposes. See question 23.*

30. ***What is the responsibility of a state-operated facility other than a juvenile correctional facility to transfer pupil records of a child with EEN who transfers to a school district, a private school, or a juvenile correctional facility?***

Under current state law, the only state-operated facility required to send pupil records of a transfer student is a juvenile correctional facility. Therefore, state-operated facilities other than juvenile correctional facilities must obtain the parent's written consent before sending a child's pupil records to another school district, private school, or facility.

attachments: Sample statement regarding "Access to Patient Health Care Records"
Sample "Notice for Child Find Activity"

This information update can also be accessed through the Internet:
http://www.dpi.state.wi.us/dpi/dlsea/een/bulindex.html

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